Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 per FH C926 4/20/2012 Jh State of Maryland Department of Health and Mental Hygiene Reg. No. 201 12001 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ C 201 Medical 4a. Facility Name (if not institution, give street and number Examiner wn, or Location of Death 4c. County of Death Baltimore Randallstown Seasons Hopsice 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 2-4-1934 Director 225-34-9527 1 🛛 M 2 🗆 F Vrs 78 VA Usual Residence of Deced item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits Director 1 ☐ Yes 2 🔀 No MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21133 9808 Marriottsville Road USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2X Married 72 hours after Baltimore, Maryland 21215-0036 Specify: African-American 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working College (1-4 or 5+) life. DO NOT use retired) Elementary/Secondary (0-12) Social Worker VA Hospital Fort Howard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ William Winfrey Sr. Lucy Hilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9808 Marriottsville Road, Randallstown, MD 21133 and 2 s Health tem 27 Lauretta R. Winfrey/Wife 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of I-Important: If ite any injury or ot cemetery, crematory or other place) 4-24-2012 Donation 5 Other (Specify) Garrison Forest Veterans Owings Mills, MD 22. Name and Address of Facility Wylie Fineral form P.A. of Baltimore Co. 21. Sign of Funeral Se 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ene Medical Due to (or as a conseque Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: ase 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) jo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy 2 No 1 ☐ Yes 2 No 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 1 Natural
2 Accide 28c. Injury at 5 Pending work?
1 Yes 2 No s after death. ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier 🔽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title

State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month agins DRI Medical 4a. Facility Name (if not institution, o've street and number, City, Town, or Location of Death Examiner Sounty of Death g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Security Numbe **Funeral** 219-32-6525 Months 1 □ M 2 😾 F Hours Min 10-26-1936 75 Yrs VA **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location the Maryland notified at Funeral Director MDBaltimore Randallstown 1 ☐ Yes 2 🎇 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be 23a Page 1 and 2 should be filed within 72 hours after death with 9525 Oak Trace Way 211.33 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ō 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify African-American 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates "natural" 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
77 is marked other than traumatic event, the Me Elementary/Seconday (0-12) 12th College (1-4 or 5+) Radiology Clerk Sinai Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James O. Morris Pauline Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Lastcha Wiggins/Daughter 9525 Oak Trace Way, Randallstown, MD 211.33 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Warrial 2 Cremation 3 Removal from State 4-18-2012 King Memorial Park Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wile Funeral Hone F.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause are each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ nine diate disease or condition Medical resulting in death) Examiner nous Saguer tially list condition of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and I for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy signed by the atte Month Day Year 5 Other (specify) Pregnant at time of death Yes ___ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes plnods peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an page 2 s After this certificate has Yes 25. Was cose referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Yes 1 Inpatient 2 R/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Mann of Death Certificate: 28b. Time of 28d. Describe how injury occurred injury Matural 5 Pending Investigation Accident 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 To the I

DHMH 17 Rev 7/2009

State Registrar Crust Kd Ranglallsman,

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To tl	M	29b. Signature and title of certifier	Jul	M) 2	9c. License		16			nth, Day, Year)
		30. Name and address of person who	completed course of	death (Item 23a) (T	vne Print)		20073	Part	41	12/1	

DHMH 17 Rev 1/2001

State Registrar

Box 68760

P.O.

Division of Vital Records,

DHMH 17 Rev 1/2001

29a. Certifier

(check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

Medical

and manner stated.

MWARINGWE

32. Registra s Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death WMYSON ROBGAT APRIL 2012 1030 A_M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **GLEN BURNIE** ANNE ARUNDEL 609 STEWART AVE. cial Security Numb 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **XX** 1 M 2 D F 251.84.4378 Hours Min. 64 APRIL 24, 1947 10a, State 10c. City, Town or Location 10d. Inside City Limits MD ANNE ARUNDEL **CLEN BURNIE** 1 Yes 2 XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 609 STEWART AVE. 21061 USA 12. Was Decedent Ever in U.S. Armed Force 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes XX No Specify: WHITE Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **MAINTENANCE WEST INCHOUSE** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROBERT B. WAYSON, SR. MARY WOODWARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA DEMARIO SISTER 8559 CHRIS CT. PASADENA, MD 21122 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) BAYVIEW CREMATORY INC. 4.10.2012 BALTIMORE, MD 21. Signature of Funeral Service Lice see FANRTUNERALS HOME! P.A. K. CRECORY KINK M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part 1 Enter the diseas shock, or heart failure. L complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition EMPHYSEM resulting in death)

Medical Examiner

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Department of
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of Health and Mental item 27 is marked

Director

Funeral

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Completed

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within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

attending physician a for use as the burialcertificate ha

requires that the death certificate be

Hospital or Attending Physician: The

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopi 4 Pregnant at time of death 5 Other 9 Unknown	ic pregnancy (specify)		23d. Date of delivery Month Day	Year
Part II. Other significant conditions con	ntributing to death but not resulting in the underlyin	ig cause given in Part I.		use contribute to the cause	
			24a. Was an autopsy performed?		igs available of cause of
25. Was case referred to medical examiner? 1 Yes 2	ospital:	26. Place of Death (Chec	k only one) ome 5 Residence	6 ☐ Other (Specify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury M		28d. Describe how inju		
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factobuilding, etc. (Specify)	ory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route N e)	umber,
(Check 2 \(\sumeq\) Medical Examin	cian: To the best of my knowledge, death occurred er: On the basis of examination and/or investigation, in Practitioner: To the best of my knowledge, death o	in my opinion, death occurred a	t the time date and place	e and due to the cause(s) and	l manner stated.
29b. Signature and the of certifier		9c. License number	29d. D	ate signed (Month, Day, Year,	
30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, Print)	HANDVERS			

State Registrar

within 24 hours a

To the Funeral D

completely filled

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rufina Young Medical 4a. Facility Name (if not institution, give street and nu vn. or Location of Death Examiner 4c. County of Death 6 if Under 24 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Min (Month, Day, Year) 1 🗆 M 2 65 Director 212-48-0059 MD 19 Usual Residence of Decedent 10b. County within 72 hours after death with the Maryland 10a State 10c City Town or Location 10d. Inside City Limits must be notified at Director 28a-f Baltimore NA MD 1X Yes 2 □ No 10e. Street and Number ö 10f, Zip Code 10g. Citizen of What Country? Funeral U.S.A. items 23a 21207 6303 Monika Place Apt 1301 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ö 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 ☐ Yes 2√☐ No Specify. Specify. "natural", 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Bementary/Seconday (0-12) College (1-4 or 5+) Deli Clerk Supermarket 12th event, Be be filed \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William R. M. Perrin Levinia Gardner permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic. once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21619 Sonja Schmidt - Daughter P.O. Box 4 Chester, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Site Cremation Ctr. 4/14/2012 |Baltimore, Md Signature of Funeral Service Licenses 22. Name and Address of acidst 21215 Baltimore, 4300 Wabash Ave, 23a. Part . Enter the disease, or complications that ca shock, or heart is ure. List only one cause on each sed the death. Do not ente Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or a a conseque Cause (Disease or imjury that initiated events attending physician and Due to (or as a consequence resulting in death) Last Physician/Medical The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the Unknown 9 Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Completed 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? After this certificate 1 Yes 2 No Yes or Attending Physician: eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 🔲 Yes 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 🔀 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide within 24 hours at er To the Funeral Direct City or Town, State) the Hospital Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat and title

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 12008 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April William Carl Anthony 17, 2012 6:20 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie 104 Sunset Drive Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Davs Hours (Month, Day, Year) Director 220-94-5418 1**X** M 2 □ F 48 Aug 30. 1963 Tennessee Usual Residence of Decedent 28a-f shov 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Glen Burnie 1 Yes 2 X No Anne Arundel 5 10e. Street and Numbe 10g. Citizen of What Country? 23a Funeral 104 Sunset Drive 21060 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. by 1 Never Married 2 Married Yes 2X No Yes, Give 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates giene. er than "natur t, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Shuttle Driver Hotel | Hygie other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental is marked o မ Donald Carl Anthony Patricia Johns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau Shirley D. Anthony, Wife 104 Sunset Drive Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Metro Crematory Inc. | 04/18/12 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between MONTAS Physician/ disease or condition resulting in death) Medical Due to (or as a cons-Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and I-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 🗌 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performe 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O. After this certificate after death.

Baltimore, Maryland 21215-0036

within 24 hours after des To the Funeral Director completely filled in by th

Medical

Accident

3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

1 Yes 2 No

IDV

29b. Signature DO058779 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KARL KASAMON 305 HOSPITAL Dr. Glen Burnie mo 21061

Registrar

31. Date filed (Month, Day, Year)

Investigation

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TITEM#10e, perFH, G926, 4/18/2012, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 535 Month Physician/ 0R Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** TIMONIUM BALTIMORE MAYS CHAPEL ASSISTED LIVING 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Min. Months Hours 219-18-3220 Director 1 X M 2 □ F Yrs MD 05/03/1925 86 Usual Residence of Decede 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County at Director must be notified 1 🗌 Yes 2 🛛 No MD BALTIMORE TIMONIUM 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code o $\frac{12661}{12261}$ Funeral items 23a 21093 ROUNDWOOD ROAD, #412 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. 0 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural", 3 Widowed 4 Divorced WHITE Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 h and Mental Hygiene. 7 is marked other than "r WHOLESALE CANDY & College (1-4 or 5+) Elementary/Secondary (0-12) the ACCOUNTANT TOBACCO Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ပ MERVIS other traumatic **ABRAHAM** ASKIN ROSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is to any injury or any 12661 ROUNDWOOD ROAD, #407, TIMONIUM, MD 21093 MARGUERITE ASKIN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MEADOWRIDGE MEM. PARK 04/15/2012 ELKRIDGE, MD 21. Signatu 22. Name and Address of Facility SOL LEVINSON & BROS., INC. MD 21208 PIKESVILLE, 8900 REISTERSTOWN ROAD, 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause is each line. Approximate Interval Between Onset and Death Immediate Cause (Final sla Physician 101 disease or condition resulting in death) Medical Due to (or as a consequent e of **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day ō Month Year 5 Other (specify) Pregnant at time of death be detached Division of Vital Records, P.O. þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed ρ 2 No 3 Probably 4 nknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy has perform death? 2 🗆 No 1 🗌 Yes certificate Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Certificate: To Be examiner? Ussistea 2 X 10 Hospital Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this Luur 27. Manner of Death 1 Natural 2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred after death. Director: After injury 5 \square Pending 2 🗌 No Investigation filled in by the 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral D Medical dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 10 of person who completed cause of death (Item 23a) (Type, Print 30. Name and address 101 021 31. Date filed (Month, Day, Ye APR 18 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7. Age (In yrs. last birthday) If Under 24 Funeral 8. Date of Birth 9. Birthplace (State or Foreign Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? Funeral or items permit. Page 1 and 2 should be filed wirthin 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 \square Never Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral 22. Name and Address of Pacility 110W 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Pregnant death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav 5 Other (specify) Year 1 ☐ Yes ∠ ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 onknown 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? 2 🗆 No 1 Tes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 11 Natural 5 Pending (Month, Day, Year) 1 Tes 2 No Accident Investigation after death Director: / 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of myknowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause eath (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Deat) Month Physician/ BUTLER MANCI ton: Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Conowingo Cecil 600 Conowingo Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 214-80-7408 Director 1 🛛 M 2 🗆 F 53 Yrs Indiana Nov 17, 1958 3a or 28a-f show t be notified at 10c. City, Town or Location 10d. Inside City Limits 10b County vithin 72 hours after death with the Maryland 10a. State Director 1 Yes 2 No Conowingo Maryland Cecil 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a Funeral 21918 600 Conowingo Road USA Medical Examiner must 'natural", or items 12. Was Decedent Ever in U.S Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Roofer traumatic event, the Carpenter / Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Kennedy Fred Richard Butler 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh. Department of Heath ar Important: If item 27 is any injury or other trau 600 Old Conowingo Road Conowingo, Maryland 21918 Dorothy Butler, Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland Metro Crematory Inc.: 04/16/12 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, Approximate shock, or heart failure. List only one Interval Between Onset and Death Immediate Cause (Final disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical Box 68760 attending properties as as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown the a P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 6 Unknown Division of Vital Records, Completed page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy perform After this certificate has To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be 2 **X**No 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural Natural 5 Pending Accident Investigation completely filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one 29b. Signature and tit ted cause of death (Item 23a

State

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Pearl Maria Bryant April 16,2012 11:50 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Future Care Cherrywood Baltimore County Reisterstown Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Sept. 02, 1924 214-24-6744 Baltimore, MD. Director 87 Usual Residence of Decedent 28a-f show 10a, State 10b. County Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Baltimore County Cockeysville 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? with 1 23a Funeral 404 Wake Robin Drive United States 21030 items 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 10 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give Year or Dates "natural", Completed 3 X Widowed 4 Divorced event, the Medica 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. permit. Page 1 and 2 should be filed within 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M any injury or other traumatic event, the M ones. Elementary/Seconday (0-12) College (1-4 or 5+) 08 N/A Retail Clerk Woodward & Lothrup Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Pearl Maxfield August Geiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr.Robert Bruce Bryant (son) 404 Wake Robin Drive Cockeysville, MD. <u> 21030</u> 20a. Method of Disposition 20b. Place of Disposition (Name of (Harford County) Wednesday 1 ☐ Burial 2 ☐ Removal from State Evans Funeral Charel and Cremetion Services, Inc. April 18,2012 Forest Hill, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licens effrey L. Gair, Sr. CFSP Property Affress of Funeral and Cremation Center, P.A. / Lic. #M00677 2325 York Road Timonium, Maryland 21093-2215 rt . Enter the disease of complications that caused nock, or reart failure. Lift only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Thy sician/ Vascular disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant 5 Other (specify) Month Day Year Pregnant at time of death should be detached 1 ☐ Yes ∠ € 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown been 24b. Were autopsy findings available 24a, Was an cate has prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy After this certificate Yes funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2. ENO Hospital: Other: ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 \(\sum \) Yes 2 \(\sum \) No 1 Natural 5 Pending death. 2 Accident
3 Suicide Investigation 124 hours after deat e Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. filled in by 4 Homicide determined Hospital Lettifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my apicles, death occured, and the cause(s) and manner as stated. Medical 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 0 4/17/12

Registrar

State

marie Mule

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1525

Mills

D47683

Z1117

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** April 14 2012 4:30p Anna J. Bowler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Franklin Woods Nursing Center Rosedale If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 219-12-8563 1 M 2 TXF 87 Director Aug. 26, 1924 MD Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits at d other than "natural", or Items 23a or 28a-f sh event, the Medical Examiner must be notified Essex 1 ☐ Yes 2 ☑ No Baltimore Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21221 84 Berkshire Road Items 23a death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. s marked other than "natural", or Ite 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 by ! 1 ☐ Yes 2 No Specify. White Specify: 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Western-Electric Secretary 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Emma E. Krug Joseph Jondo other traumatic ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9007 Lennings Lane Baltimore MD 21237 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sl ment of Health an tant: If item 27 Is I Charles Jondo /cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Cemetery 4/19/12 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. Home of Essex Connelly Funeral 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician FVG /Medical Due to (or as a consequence (f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter thinderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If ves. outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 mont 1 Yes 2 No 9 Unknown Month Year Day 5 Other (specify) P.O. | ed by the a detached f signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe page 200No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one 1 ☐ Yes 2 No Other: P 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural (Month, Day Year) 5 Pending death. Accident investigation 1 ☐ Yes 2 ☐ No al or Attend after death. 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) l in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

Jude Munesus 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MO

W 12

APR 1 8 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Mondonia

29d. Date signed (Month. Dav. Year)

Ct. Follston, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Hazel I. Blevins 04701/2012 Year Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Citizens Care Center Havre de Grace Harford 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Days **Director** 223-28-0077 Hours Min 1 □ M 2 🗶 F 90 04/13/1921 Usual Residence of Decedent Virginia 28a-f show filed within 72 hours after death with the Maryland 10a. State Director 10b. County 10c. City, Town or Location must be notified 10d. Inside City Limits Maryland Harford Havre de Grace 1 X Yes 2 No or 10e. Street and Number 10f. Zip Code "natural", or items 23a Funeral 10g. Citizen of What Country?
United States of 106 Bayland Drive Unit 19 21078 11. Marital Status America Examiner 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Armed Forces?
1 ☐ Yes 2 X No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed Yes, Give 3 Widowed 4 Divorced 1 ☐ Yes 2 🔀 No Specify: White Year or Dates. Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Be Registered Nurse <u> Health Care</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Franklin Reedy Phoebe Jane Waddell 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) Grace . Page 1 and 2 shoutment of Health and tant: If item 27 is nuy or other traum 19a. Informant's Name/Relationship (Type, Print) <u>Sandra Bea Hash (daughter)</u> 204 Secretariat Dr. Unit P Maryland 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Aberdeen, Maryland Harford Mem. Gdns 04/05/2012 21. Signature of Funeral Service Men ee 22. Name and Address of Facility Zellman Funeral Home, P.A. S. Washington St. Havre de Grace, 23a. Part 1. Enter the disease, or shock, or heart failure. List mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Levebre Sonset and Death Valudar Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Examine Due to (or as a consequence that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available autopsy this certificate prior to completion of cause of performed death? 2 🗌 No Be 25. Was case referred to medical examiner? Yes 1 Tes 26. Place of Death (Check only one) ၉ 1 ☐ Yes 2 ☐ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death Director: After 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? Accident Accident Investigation 2 🗌 No Suicide 6 Could not be hin 24 hours after the Funeral Direc 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Within To the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) William 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M132107 76. 1106 Revolution St. Havre De Grace Kammaly Milian, 31. Date filed (Matherly, Year) State 92. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Depedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Facility, Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death more last birthday Date of Birth (Month, Day If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Min. Country) Director Jsual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1X Yes 2 ☐ No Himore 10f. Zip Code 10g. Citizen of What Country? 04 Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Be Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Black 3 Widowed 4 Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DΦ NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nurses unland 17. Father's Name (First, Middle, Last) Unkwin 18. Mother's Name (First, Middle, Maiden Surname, ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a Method of Disposition 20b, Place of Disposition (Name of 20c. Location - City or Town, State cemetery 1 Durial 2 Cremation 3 Removal from State cramatory or other pla 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of). within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? 2 🗌 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniurv work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) 10060500 3 completed cause of death (Item 23a) (Type, Print) STEMMERS 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 1 per doc g926 4-18-12 yt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2012 12016 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Michele Doyle-Shipman Month 4 Physician/ Year 2323 M Medical 4a. Facility Name (if not institution, give street 4b. City, Town, or Location of Death Examiner 4c. County of Death Boltimare Maryland 07 7. Age (In yrs. last birthday) If Under 24 Hrs. If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) 217-48-5 179 **Director** 1 🗆 M 2 🔀 F Yrs 56 4-29-1953 Usual Residence of Decedent ar Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and I flems 23a or 28a-f show and I flems 23a or 28a-f show the the than "hatural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 0d. Inside City Limits Director J Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral St. 2121 1510 W. Mosher 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 →No Specify. Specify: Completed 3 ₩ Widowed 4 □ Divorced 13/ack 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) lenk (2007 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည Fauntleru 11:01a Mar James 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Whith Balto. Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) '
recement Crematory 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balto. ad. 4-23-2012 Signature of Funeral Service Licenses Name and Address Funeral Service Dalto 1701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ complications of COCHINO disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ENTERNION Nº PRINCIPE OF MEDICAL Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 ☑ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I performed' within 24 hours after death.

To the Funeral Director; After this certificate 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Z Yes Other: 2 🗌 No ၀ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of Medical Certificate: 28d. Describe how injury occurred injury 5 Pending 1 Natural Unkeneown Accident Investigation 03/16/2012 MYNEW 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1510 W MOSTW Street 15(1) MWC, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Mome 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P in Kritchard Miss Res 001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Pritchard 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 1 per PHYS, G926, 4/18/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Mary Claire Davis Physician/ Month Year 04 2012 12:52 A M TERAN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BAUTIMORE MARIS AUSTC Hospice I Ess SON **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Min. Country 220-54-8733 **Director** 1 - M 2 X F 86 Usual Residence of Decedent - 09permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director BALLIMORE MD Yes 2 No Baltimore, Maryland 21215-0036 / Apm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Ballons 21213 6806 AJENUE 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Black, White, etc. þ If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5 Duc Ation of DUCATOR Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) ဂ JAmes ATHERINE 19a. Informant's Name/Relationship (Type, Print) (P. 2.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , Sue Weden KAMP 6806 DVA MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cemerer 4 ☐ Donation 5 ☐ Other (Specify) SAVANAH GA 04-15-2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2134 Willow Speing RD ASHION F.H.R.A PACH MB 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death HEART DNEESTIVE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a punticulation of and -trar Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical requires that the death certificate be DAVIS Division of Vital Records, P.O. Box 68760 IF FEMALE: IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 18 1 Yes 2 Year Month Pregnant at time of death 5 Other (specify) Day ed by the a detached t No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law autopsy performed 1 Yes 2 No page certificate 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 4 Nursing Home 5 Residence Other (Specify 27. Manufer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1
Yes Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending injury 2 🗆 No Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Geraldine V. Delss 18 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE Rosedale Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 220 – 30 – 6571 7. Age (In yrs. last birthday) **Funeral** Months Days Mir Director 1 □ M 2 1 F 75 Yrs Aug. 16, 1936 MD 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director MD Baltimore 1 Yes X No Essex 10e Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 408 Essex Avenue 21221 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc or. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Salesperson 11th Today's Linens Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Vincent Powell Viola Zezulinski elss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 George Delss Jr. /husband 408 Essex Avenue Baltimore MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Holify Hill the metery 4/21/12 injury or Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) Balto. Mud 22. Name and Address of Facility 300 Mace Ave. 21. Signature of Funeral Service Licen any in Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. val Betweer and Death Immediate Cause (Final ~Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence **To the Hospital or Attending Physician**: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 🥓 physician Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregn 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 month Pregnant at time of death
Unknown Month Day been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy perform certificate Yes funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation after death filled in by the Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title 29c. License numbe 29d. Date signed (Month, Day, Year) 4-17-2012 10057021 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 9106 Philadelphia Rd Ste106, Baltimore MD 21237 MATHUR 31. Date filed (Month, I PR 1 8 2012 State

Registrar

eraldi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend State of Maryland Propagation of the Blth and Mental Hygiene

2012 12019

		- For State Registrar	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Certific	cate of	Death			eg. No.	Ula	2 1201
Physician Medical Examine	er	Decedent's Name (First, Midd	Daphr		Dra			2. Date of Dea Month April 12, 2	Day Y	'ear	3. Time of Death 2009 hrs
		4a. Facility Name (if not institution Johns Hopkins Bayvie	ew Medical Center			b. City, Town, o Baltimore			1	ty of Death N/A	
Funeral Director	L	5. Social Security Number 217-30-3021	6. Sex 7. Ag	ge (In yrs. last bi	irthday) Yrs.	If Under 1 Ye Months Da		Min.	th(MM/DD/YY	Foreig	thplace (State or gn untry) VA
Aaryland 28a-f show any 1 at once.	Ī	Usual Residence of Decedent 10a. State 10b. County MD Ba	altimore	10c. City, Tow	n or Locatio	on		Dunda1k			10d. Inside City Limits 1 Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.		10e. Street and Number	ce Road			10f. Zip Code	2	1222	Og. Citizen of V		
5	alin.	11. Marital Status 1 Never Married 2 M 3 X Widowed 4 Div	12. Was Decedent Armed Forces 1 Yes 2 vorced If Yes, Give Year		If Ye	Decedent of Hes, specify Cuba	n, Mexican, P	? (Specify Yes or No uerto Rican, etc.)		nite, etc.	can Indian, Black, White
5-0036 ed within 72 hours aft edwithin 72 hours aft other than "natural" the Medical Examine	Տ -	15. Decedent's Education (Spe Elementary/Secondary (0-12)	or Dates: cify only highest grade cor		. Decedent during mo	's Usual Occupa st of working lif	ation (Give kin e. DO NOT us	d of work done e retired)	16b. Kind of	Business/l	ndustry
215-003 be filed within ntal Hygiene. rked other the med the Medi		8 Years 17. Father's Name (First, Middle, Charles Ast			Но	usewife	18.Mother's	Name (First, Middle,	Maiden Surnan	,	1e
MD 21215-0036 12 should be filed within 7 th and Mental Hygene. 127 is marked other than unatic event, the Medica	2	19a. Informant's Name/Relations Ronnie Drake (hip (Type, Print)				L et and Numbe	er or Rural Route Nur oad Dunda	mber, City or To	own, State	
Baltimore, Definit. Pages and Department of Heal Important: Vitem		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Sp	pecify:	ate crema	atory or other	ervice	Corp.	Date 4/16/2012		on, M	aryland
	[2	21. Signature of Funeral Service 223a. Part I. Enter the disease, or	Scott P		1 79	22 Wise	A170	al Home of Dundalk, 1	farylan	d 21	.222
Physician Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	1 and F				nac or respiratory arr	est, snock, of r	eart	Approximate Interval Between Onset and Death
		Sequentially list conditions, fany, leading to immediate	b. Due to (or as a conse	equence of):							
outed ransit		(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse								
760, crate be executed physician and the burial - trans	1	UNPENDED FEMALE:	AMENDED 236			Ba-f,pe	r me,g9	026 5-2-12	SIII 23d. Date	of delivery	
		3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Univ	1 Live birth	Alman of danath	2 Feta	al death 3 er (Specify)	Ectopic p	regnancy	Month	,	ay Year
P.O. Bires that the disagned by the detached the detached the disagned by the disagned by the disagned by Physics		Part II. Other significant condit				nderlying cause	given in Part I	23e. Did to		-	the cause of death?
of Vital Records, P.O. Box 68' og Physician: The law requires that the death certifi wher this certificate has been signed by the attending meral director, page 2 should be detached for use as in: TO Be Completed by Physician.								1 Yes	osy rm <u>ed</u> ?		topsy findings available ompletion of cause of s 2 No
Vital I vysician: this certifi director,		25. Was case referred to medical examiner? 1 Very 2 No	Hospital:	ent 2 🗸 ER/0	Outpatient		Other -	neck only one) lursing Home 5	Residence 6	Other	:
ion of Vital I ttending Physician: death. rtor: After this certifi y the funeral director, y the funeral director, antion: To Be C		7. Manner of Death 1 Natural 5 Pend 2 X Accident Inves	28a. Date of Inju (Month, Day,Y stigation fd 4-12	'ear)	Time of Inj	1	ury at Work? Yes 2 Ϫ N		how injury occu		edications
Division of the Bopital or Attending hin 24 hours after death. the Funeral Director: After pitetely filled in by the funcial Centification:		4 Homicide deter	rmined (Specify)	Found: Re	esider	nce		or Town, S Dundalk	tate) 1934 ., MD	Hase	ral Route Number, City 1mere Rd.
To the Hospital within 24 hours a To the Funeral I completely filled	100	Check only 2 Medical Example	hysician: To the best of m miner: On the basis of exal and manner stated.			on, in my opinio	n, death occur		and place, and	due to the	e cause(s)
		19b. Signature and title of certifie				29c. Licen	M.E.		April 13, 2		nth, Day,Year)
Ψ		Russell Alexander MD				V. Baltimore	Street, Ba	altimore, MD 21	223		
State Registra		1. Date filed (Month, Day, Year) APR 1 8 2012	32. Registra	r's Signature	25						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#20b, perFH, G926, 4/18/2012, WS State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 2. Date of Death Decedent's Name (First, Middle, Last) Day 12-111 Month SHEILA, DANOWITZ Physician/ 08:10AM 2012 APRIL Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** RANDALLSTOWN BALTIMORE HOSPITAL NORTHNEST If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 104-30-3074 1 □ M 2 🛛 F Director Yrs 06/08/1938 NY 73 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director 1 Yes 2 X No BALTIMORE MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21209 2703 SUMMERSON ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 12. Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 No Specify. Baltimore, Maryland 21215-0036 If Yes, Give Specify: "natural", 3 Divorced 4 Divorced WHITE Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry A and Mental Hygiene.

7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) MANUFACTURING ADMINISTRATIVE ASSISTANT traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ RICHMAN IDA KAMINSKY HARRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) it of Health 2703 SUMMERSON ROAD, BALTIMORE, MD 21209 LOUIS DANOWITZ/HUSBAND 20c. Location - City or Town, State 20a, Method of Disposition Atishe Emunah Altz Chaim 1 X Burial 2 Cremation 3 Removal from State Department o Important: If any Injury or once. ò 04/16/2012 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death ASPIRATION PNEUMONIA SEPSIS HYPOXIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dusite (or as a consequence of): attending physician and I for use as the burial-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ungence Hypertemul 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 N Inpatient 2 ER/Outpatient 3 DOA funeral 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after dea

To the Funeral Director

completely filled in by th 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29d. Date signed (Month, Day, Year)
APRIC, 1241, 2012 29b. Signature and title of certifier 29c. License number el HOSPITALIST D63126 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21133 COURT ROAD RANDALLSTONU, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ Month Lena Evans a.M. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A **Examiner** Town, or Location of Death If Unde If Under 24 Hrs 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 70 8. Date of Birth **Funeral** 216-42-5019 Months (Month, Day, Yea 6/13/41 1 □ M 2**X**□ F **Director** 28a-f show N/A 10c. City. Town or Location with the Maryland notified at 10d. Inside City Limits Director MD Baltimore X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? ō 10f. Zip Code must be r Funeral 21213 2709 Edison Hwy USA items ? death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) and Mental Hygiene.
is marked other than "natural", or iten 11. Marital Status 14. Race - American Indian, Armed Forces? African þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 be filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Amer. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Warehouse College (1-4 or 5+) Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Evans Rose Evans permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marken any injury or and 19a. Informant's Name/Relationship (Type, Print)
Frank Weaver/Son 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2932 E. Fayette St., Balt., MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State oaklawn Cem. or other place) 4/21/12 Balt.,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Ser 22. Name and Address of FacilityHari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition Medical resulting in death) **Examiner** nome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine use as the burial-transit Cause (Disease of Injurathat initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months 1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) io the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 000 Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tes 1 Inpatient 2 PR/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Deat Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated for the place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge. (Check only one 29b. Signature a

Registrar

DHMH 17 Rev 06-2011

State

30. Name ;

00 S

completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 12022 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0830 AM 2012 FLUIS ZANNE Medical 4a. Facility Name (if not institution, give stre and number) Town, or Location of Death 4c. County of Death Examiner HOS PITAL TIMORE 8. Date of Birth (Month, Day, Dec . 31 9. Birthplace (State or Foreign Birthpic Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕱 F Months Hours 220-66-2491 Director 54 Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Director MD Baltimore Essex 1 Yes 2 No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 6 Woods Court 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 Married "natural", or þ hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker own home 12th Be filed permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas A. Lloyd Edith Tallebast 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Foster /brother-in -law 6 Woods Court Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 4/12/12 Baltimore MD 22. Name and Address of Facility 300 MAce Ave. Signature of Funeral Service Licensee Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ NEVMONIA disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, reading to introduct cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed and I-tran Due to (or as a consequence of): physician ar Physician/Medical P.O. Box 68760 attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) the Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by ARDIAC ARREST 4 Unknown 2 No 3 Probably Division of Vital Records, 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? LEURAL EFFUSION within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☑ No Yes 2 25. Was case referred to medical examiner? To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes ည 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

only one 29b. Signature and titl

30. Name and address of person

2000

MID, ppleted cause of death (Item 23a) (Type, Print) 29d. Date signed (Month, Day, Year)

Baltimore STREET

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

eorge E. Ewing	-	State of Maryland / Department of Health a For State Certificate of Death egistrar	and Ment	tal Hygiei	ne Reg	-	12	1202
Physician edical Examine	/ 1	I. Decedent's Name (First, Middle,Last)		2. Dat	e of Death			3. Time of Death 0024 hrs
	George E. Ewing 4a. Facility Name (if not institution, give street and number) Johns Hopkins Bayview Medical Center Month Day April 14, 2012 4b. City, Town, or Location of Death Baltimore 4c. County of Death Baltimore							
Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 $212-92-9054$ $1\times M$ 2 F 50 Yrs.	Year If Under Days Hours	1 10	ate of Birth		Foreign	nplace (State or n intry) MD
any	_	Jsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location						10d, Inside City Limits
		MD Baltimore Co. Dundalk						1 Yes 2 No
th the Maryland 23s or 28s-f show notified at once.		Oe. Street and Number 10f. Zip Coo			10g	. Citizen of Wh		try?
with the Maryland as 23a or 28a-f she be notified at once real Director		2820 Plainfield Road 21 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent o	1222 of Hispanic Origi	in? (Specify Y	es or No-		SA - Americ	ean Indian, Black,
or death with or items 23		1 Never Married 2 X Married Armed Forces? If Yes, specify Cu	uban, Mexican,			White	, etc.	
a di di	5	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occ	No specify:	rind of work do	ine I1	Specify: 16b. Kind of Bus		ite
72 hour natt		Elementary/Secondary (0-12) College (1-4 or 5+) during most of working	g life. DO NOT u	use retired)		Pimlic		
5-0036 lied within 72 hours Hygiene. I other than "natur the Medical Exam		10 Security 77. Father's Name (First, Middle, Last)				Course		
21215-0036 uld be filed within 73 Mental Hygiene. marked other than c event, the Medical		James Ewing, Sr.				Carbac		
ID 21 t should and Mer 27 is man	2 1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (S						
≥ 중절일일		Janet Ewing/Wife 2820 Plair 20a. Method of Disposition 20b. Place of Disposition (Name of		Date		20c. Location -		
Pages lent of l		1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Bayview Crematory	atory	4-16-2	2012	Balti	mor	e, MD
Baltimore, permit. Pages I an Department of Hes Important: If itel injury or other tr		21. Signature of Funeral Service Licensee 22. Name and Add	dress of Facility	Kaczo:	rows	ki Fun	era	I Home, PA
Physician	2	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dy						MD 21222 Approximate Interval
Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Narcotic (Morphine) Intoxi	cation				§	Between Onset and Death
	1	or condition resulting in death) Due to (or as a consequence of): b.						
, de	E i	Sequentially list conditions, fany, leading to immediate Due to (or as a consequence of):						
ecuted and transit	Ya!	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
0, the execut sician and ourial - trai	3	x UNPENDED AMENDED 23a,27,28a-f,per me,	g927 5-	-2-12 s	m			
		F FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the	3 Ectopic	pregnancy		23d. Date of Month	delivery Da	ay Year
b. Box 6876(the death certificate the attending physched for use as the b	2	past 12 months? 4 Pregnant at time of death 5 Other (Specify)		pregnancy		Monar	D.	ay roan
o. Bc		Part II. Other significant conditions contributing to death but not resulting in the underlying cau	use given in Par	rt I. 2	3e. Did tob	acco use contri	oute to t	he cause of death?
D the Se of the				[1 Yes	2 No 3	Proba	ably 4 🗹 Unknown
of Vital Records, as Physician: The law require the this certificate has been signed at the completed of To Be Completed.				24	4a. Was an autopsy perform	р		opsy findings available ompletion of cause of
tal Rection: The certificate ector, page		25. Was case referred to medical 26.P	Place of Death (✓ Yes 2		✓ Yes	s 2 No
F Vital Physician: rr this certif	٥l	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Othor			esidence 6	Other:	
n of Vita ding Physicia h. After this cer	2 2	1 Natural (Month, Day, Year)	Injury at Work?	,	escribe ho	w injury occurre	ed	
Division or spital or Attending to the spital or Attending to the spital or Attending to the spital or by the function of the spital or	3	Pending Investigation Suicide		c. 28f. Lo	ocation (Str	reet and Number	r or Rur	al Route Number, City
Divi		4 Homicide determined (Specify) Found: Residence		Dun	dalk,	MD.		field Rd.
the H hin 24 the Fu	E 7	Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinand manner stated.						
To con	2	29b. Signature and title of certifier 29c. Lic	cense number		1	29d. Date signe		th, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)).C.M.E.			April 14, 20	12	
4		Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore S	Street, Baltir	more, MD 2	21223			
Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature						
DHMH 17 Rev 1/200		APR 1 8 2012 Central B. Marginal				(CME	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month -Ehinnu Nwaka 2202 -2012 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore, MD University of Mamland Medical Center If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** Days Director 213-69-4374 1 □ M 2√13 F 56 05/12/1955 ANAMBRA, NIGERI Usual Residence of Deceden or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No MD BALTIMORE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 23a 3307 FAIRVIEW RD 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. "natural", or 1 Never Married 2 Narried Completed by 1 Yes 2 If Yes, Give Year or Dates. 2 X No 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced AFRICAN AMERICAN Der nit. Page 1 and 2 should be filed within 72 hour begrantment of Health and Mental Hygiene.

— Figure nit. If item 27 is marked other than "natur any injury or other traumatic event, the Medical I one. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12 HOUSEWIFE DOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ AGBUKA OKONKWO JEANETTE OKONKWO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3307 FAIRVIEW RD. BALTIMORE, MD 21207 GREGORY ETUNNU/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ETUNNU COMPOUND 06-02-2012 IMO STATE, NIGERIA 21. Signature of Funeral Service Liversee WILLIAM C. BROWN COMMUNITY FUNERAL HOME P.A. 1206 W. NORTH AVE. BALTIMORE, MD 21217 yrt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Interval Between Onset and Death Immediate Cause (Final Physician/ perforated disease or condition resulting in death) Medical Due to (or as Examiner Imonth Septic Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) 1 month liver abscen and -tran that initiated events Due to (or as a consequence of resulting in death) Last physician a sthe burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No for Dav Pregnant at time of death 1 Yes 2 9 Unknown Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 1 ☐ Yes 2 Mo 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 PNo Other: မ 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural iniury 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month. Day, Year)

Registrar
DHMH 17 Rev 06-2011

30. Name and address of

31. Date filed (Month, Day, Year)

Lan

M-Yina

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

who completed cause of death (Item 23a) (Type, Print)

22 S.Greene St

32. Registrar's Signature

P2733 I

Baltimore, MD 21201

04/16/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G927 5/02/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 2012 Phyllis Eva Flora 2:25 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Med. Ctr. Glen Burnie Anne Arundel \$2945-410-8996 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days 1 M 2 XF Months Hours 4/24/1943 Maryland **Director** 69 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland at Director notified 28a-f 1 Yes 2X No MD Anne Arundel Glen Burnie 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Completed by Funeral with 23a 226 Turnwood Drive 21061 USA death 1 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 9 Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: If Yes. Give 3 Widowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Roofing/Sheet Metal Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ Phillip Poggie Eva Marie Summers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie A. Smith / Daughter 4438 Fenor Road, Baltimore, Maryland 21227 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of F Important: If ite any injury or oth 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/18/2012 Crestlawn Mem. Gds. Marriottsville, MD permit. 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Furneral Secreta Lice see 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARDIA disease or condition Medical resulting in death) **Examiner** RONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): -transit and Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical certificate be Box 68760 as the b yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Character time of death 5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No that the death ţo Month Day Year signed by the a d be detached f 1 ☐ Yes 2 € g ☐ Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 24 hours after death.
Funeral Director: After this certificate has been sign. CHRONIC OBSTRUCTURE DLMONARY DISPACE Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should PERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) 2 No Hospital Other: ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred injury 1 Natural 5 Pending М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29b. Signature and title of certifie မ

Registrar

DHMH 17 Rev 7/2009

State

30. Name and addr

VOULTON

405 FREDERICK ROAD

of person who completed cause of death (Item 23a) (Type, Print)

120040012

SUTTE 204, CATOUSVILLE, MD 21228

12-02692 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 12026 Steven Gregory Freeman State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Physician/ 1919 hrs **Medical Examiner** Steven Gregory Freeman April 4, 2012 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death North Fast 2 Mahogany Drive If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year **Funeral** 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Director 01/22/1954 MD 58 215-60-4995 1 X M 2 F Country Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County Ceci1 1 Yes 2 X No North East imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f abov or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21901 2 Magnolia Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes Specify: White 4 X Divorced 3 Widowed Yes, Give Year Yes 2 X No specify: <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Residental Painting Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Doris Redmond Robert Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4 Rockingham Ct.Apt.K Parkville, MD. 21234 Darlene Gross - sister 20b. Place of Disposition (Name of cemetery, 20c Location - City or Town State 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department of 04/14/2012 Baltimore, Maryland Metro Crematory,Inc. Donation 5 Other Specify. Signature of Funeral Service Licensee Stephanie Custer 22. Name and Address of Facility Cremation Society of MD. Inc. 299 Frederick Road Baltimore,Maryland 21228 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Narcotic (morphine) intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. Š 1 Yes 2 V No 3 Probably 4 Unknown Chronic obstructive pulmonary disease page 2 should be Completed After this certificate has been 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital or Attending Physician: funeral director, Be Hospital: 1 Inpatient Other₄ Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA 1 Yes 28a. Date of Injury FOUND: Day,Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b, Time of Injury Certification unknown FOUND: Natural 1 Yes 2 V No Pending the Apr 4, 2012 1900 hrs Investigation 2 Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) 2 Mahogany Drive, North East, Md determined (Specify) Townhouse / Rowhouse Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: A

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

32. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

OCME

Donna M. Vincenti, MD

31. Date filed (Month, Day, Year)

ORIGINAL

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

April 5, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year/2 certach Month 4 Physician/ Day 30 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Par Severna Jeverna enesis Pa 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 XM 2 - F Min 219-38-1716 71 Director Baltimore, MD. 1940 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Co. Pasadena 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 Appian Way 21122 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 XNo Black, White, etc. 1X Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: and Mental Hygiene.
is marked other than "natural", raumatic event, the Medical Exa If Yes Give Specify. White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 04 Elementary/Seconday (0-12) 12 Computer Engineer Payroll 1 and 2 should be filed w of Health and Mental Hyginitem 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Howard Gerlach Catherine Elizabeth Bauersfeld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sharon Lee Ashley (Daughter) 5 Appian Way Pasadena, Maryland 21122 other item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Wednesday Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 4 Donation 5 Other (Specify) April 18,2012 Baltimore, Maryland Signature of Funeral Service Licenses Jeffrey L.Gair, Sr. 22 Name and Address of Facility Prescription Center, P.A. Lic.#M00677 2325 York Road Timonium, Maryland 21093-2215 art 1. Finer the disease, hock, or heart failure. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate only one cause on each Interval Between Immediate Cause (Final disease or condition Onset and Death dvance Physician/ 10 years Medical resulting in death) Due to (or as a consequence of): Examiner n Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence on as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Po Month Year Pregnant at time of death 5 Other (specify) Day 1 Yes 2 9 Unknown should be detached Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requir within 24 hours after death.

To the Funeral Director: After this certificate has been a completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2X No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1/Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of JuiteB 31. Date filed (Month, Day, Year)
APR 1 8 2012

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registra 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Physician/ Gentile APRTT. 2012 4:00 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner BALTO. TOWSON **GBMC** If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Months Davs Hours Min. 213-05-1140 1 🗆 M 2 🙀 F Director 91 MARYLAND JULY 28,1920 28a-f show 10a. State 10b. County 10c. City, Town or Location Director items 23a or 28a-f s ser must be notified 1X Yes 2 No BALTIMORE MD 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral within 72 hours after death with 228 S. EXETER STREET 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Yes, specify Cuban, Mexican, Puerto Rican. etc.) Armed Force Black, White, etc. 0 1 Yes 2X No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE "natural" Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) CONFECTIONARY STORE SELF-EMPLOYED Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ ROSE SOLAIR ARTHUR PEZZICA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. 12604 LOUISE AVENUE FORK.MD. 21051 JOANN ZIMMERMAN 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4-19-2012 BALTO.MD. 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH SCHIMUNEK FUNERALHOME, INC. Ignature Fur ara Service Livensee 22. Name and Address of Facility NOTTINGHAM, MD. 9705 BELAIR ROAD the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or complication Interval Between Onset and Death shock, or heart failure. L Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 6entonin physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Day Month Pregnant at time of death the 8 9 Unknown 9 Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director; After this certificate has b perform 2 No 1 Yes 25. Was case referred to medical examiner? ely filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital Other: ဂ္ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Maryler of Death 28b. Time of 28c. Injury at Certificate: Natural 5 Pending work? 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Sign 0028673 201 2.120 no completed cause of death (Item 23a) (Type, Print) Chorles Friedlander 1 8 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar 12029 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 2012 CLARA GORDON 02:30A Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner COPPER RIDGE SYKESVILLE CARROLL Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min 06/23/1913 154-26-6642 Director 1 🗆 M 2 🔀 F 98 Usual Residence of Decedent 28a-f shov 10b. County the Maryland an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No SYKESVILLE CARROLL MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21784 7002 BEACHMONT DRIVE within 72 hours after death 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 Yes If Yes, Give Year or Dates 1 Yes 2 No Specify WHITE Specify 3 👿 Widowed 4 🗆 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) the OWN HOME HOMEMAKER and Mental Hygie is marked other event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important if item 27 is marked any injury or other traumatin conce. ၉ SAMUEL KRUPNICK GUSSIE KATZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7002 BEACHMONT DRIVE, SYKESVILLE, MD 21784 RICHARD GORDON/SON 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) WOODBRIDGE, NJ 04/17/2012 BETH ISRAEL 22. Name and Address of Facility SOL LEVINSON & BROS., INC. PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD, 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause University of the Control of the Cont Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) signed by the sid be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed page 2 2 No After this certificate 1 Yes • Hospital or Attending Physician: 24 hours after death.
• Funeral Director: After this certific. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4

✓ Nursing Home 5

Residence 6

Other (Specify) filled in by the funeral 27. Man r of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred V Natural 5 Pending work? 2 🗌 No ☐ Accident Investigation 3 Suicide
4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 1 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) DIM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 295 ber AVC W.5minster

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 12030 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 11:55 PM William Jerome Giles 2012 4PRIL 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/ABALTIMORE HOSPITAL 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 218-60-2648 Months (Month, Day, Year) 1**★** M 2 🗆 F 12/06/1954 Maryland 57 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 🔀 Yes 2 🗌 No Baltimore MD N/A10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 21201 116 Paca St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+) Restaurants Chef 10th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shirley King William Giles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2230 Ruskin Ave., Baltimore, MD21217 Lydia Gilmor(sister) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Baltimore, MD 4 Donation 5 Other (Specify) on-site Crematory N of Juneral Service Licer நீத்து Address of Frown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line SEPTIC SHOCK Immediate Cause (Final disease or condition touz-S resulting in death) Due to (or as a consequence of) BACTERIAL MONTANEOUS Due to (or as a consequence of) LIVER GRRHOS Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an MELLIUS - TYPE autopsy performed'

Physician/ Medical Examiner

attending physician a for use as the burial-

been signed by the should be detached

that the death certificate be

or Attending Physician: The law requires

After this certificate has

Physician/

Medical

Examiner

Funeral

Director

28a-f show

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23a

or

"natural",

Baltimore, Maryland 21215-0036

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Examiner

traumatic event, the Medical

nd Mental Hygiene. marked other than

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permit. Page 1 and 2 Department of Healt Mportant: If item 2 any injury or other?

I and 2 should be I Health and Me

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

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Completed

Be

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Certificate:

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

ALCOHOL ABUSE

DIABETES

1 Yes 2 No

HUPERTENSIAN 25. Was ca e referred to medical 2 I No 1 Yes

27. Manner of Death

1 Natural

Accident

Suicide

4 Homicide

29a. Certifier

Hospital: 28a. Date of injury (Month, Day, Year) 5 Pending Investigation
6 Could not be

Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No

AVENUE

4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Ectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

26. Place of Death (Check only one)

(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated only only only only only only only only	a. Certifier i Dertifying i Hysician. To the Dest of the knowledge, death of	courted at the time, date and place, and dae to the	oudoe(s) and marrier as stated.										
	(Check 2 Medical Examiner: On the basis of examination and/or investi	neck 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state											
b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge,	death occurred at the time, date and place, and due t	o the cause(s) and manner as stated.										
	b. Signature and litle of certifier	29c. License number	29d. Date signed (Month, Day, Year)										

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determined

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900

CHINTAN 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

32. Registrar's Signature

ORIGINAL

Box 68760 P.O. Division of Vital Records,

within 24 hours after deatl

To the Funeral Director:
completely filled in by the

Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5: 10 PM Hagan, Sr. Wallace L. APRIL 15 2012 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) HOSPITAL BALTIMORE AGNES Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 M 2 □ F 90 217-14-1354 MD 01/14/1922 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21229 3711 Greenvale Rd. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Demolition Heavy Equipment Operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carmie Becraft Leo Hagan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1318 Birch Ave., Arbutus, MD 21227 Beverly A. Luers 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/19/12 Loudon Park Cemetery: Baltimore, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hubbard Funeral Home 4107 Wilkens Ave., Baltimore, MD 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RIGHT UPPER LOBE PNEUMONIA DAYS disease or condition resulting in death) Due to (or as a consequence of): MYELOMA MULTIPLE 40NTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) DAYS. Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery oregnant 3 Ectopic pregnancy Month Day Year onths? 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Janknown 24b. Were autopsy findings available prior to completion of cause of death? DIABETES 24a. Was an autopsy VASCULAR PERIPHERAL 1 ☐ Yes 2 11 MG 1 □ Yes DISEASE 2 1 NO 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\Boxed{\Delta}\) Nursing Home 1 Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

certificate be executed

Box 68760,

P.0.

Records,

of Vital

Division

Hospital 24 hours

AGAN

Department of Figure 1 in the Important: If ite any Injury or ot once.

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite

7 Is marked other than "natur traumatic event, the Medical

Baltimore, Maryland 21215-0036

Director

Funeral

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Physician/Medical

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Completed

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Certification: To

Medical

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l	IF FEMALE:
i	23b. Was decedent p
ı	in the past 12 m
ı	1 ☐ Yes 2 ☐
١	9 Unknown

5 Pending

investigation

25. Was case referred to medica

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

1 Natural

2 Accident

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29b. Signature and title of certifler Sindhuja 29c. License number P24433 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, 900 S CATON AVE. BALTIMORE, MD-21229. MARUPUDI, SINDHUJA

State Registrar

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within 24 hou To the Fune completely fi

31. Date filed (Month, Day, Year) APR 1 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1perPHYS#5perFH, G926, 4/18/2012, WS.

State of Maryland / Department of Health and Mental Hygieney 0 1 7 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Eleanora C. Hill 3. Time of Death 2. Date of Death Day Year Month 12:27 pm 2012 4c. County of Death City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) Balli more Nospita MORE COUR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7-16-1920 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Months 1 ☐ M 2 ☑ F NORTH CAROLINA Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No MD. BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1728 BRADDISH AVE. 21216 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)
-12-College (1-4or 5+) -0-CLERK SEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN JOSEPHINE HARRIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) THURMAN HILL (HUSBAND) 1728 BRADDISH AVE. BALTIMORE, MARYLAND 21216 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ARBUTUS MEMORIAL PARK 4-20-2012 BALTIMORE, MARYLAND * 4 □ Donation 5 □ pother (Specify) HIENER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. JONATHAN of Euroral Service Lice 21. Signal 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a, Part1 Onset and Death Immediate Cause (Final STHMA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to fur as a consequer co of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 Yes 2 No 1 Yes 26. Place of Death (Check on one 25. Was case referred to medical examiner? Other: 4 Thursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ENOutpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

27 is marked other than "natural", or itema 23a traumatic event, the Medical Examinar must be Baltimore, Maryland 21215-0036 f Health other Department of H Important: If ite any injury or of once. **Physician** /Medical **Examiner** or Attanding Physician: The law requires that the death certificate be executed ifter death. detached Division of Vital Records, P.O. After death. after death Diractor: the filled in by To the Hospital within 24 hours at To the Funeral D

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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must be notified at

Director

Funeral

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Completed

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Examiner

by Physician/Medical

Completed

Be

Certification: To

Medical

29a, Certifier

the Maryland

death

filed within 72 hours after

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> State Registrar

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arlene APR 1 8 2012

29b. Signature and title of certifier

RoBins 6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000 MD 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

4 com

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Bultimone Maryland

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM# 20 PET HTS, G 26, 4, Fo 2012, W Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 12033 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 04:15 PM HANDEL 04 2012 MARGARITA ic Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE N/A SINAI HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Hours Months Country) 1 🗆 M 2 🔀 (Month, Day, Year) 02/22/1922 COLOMBIA 294-32-9648 Director 90 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 X Yes 2 No BALTIMORE MD N/A 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 USA 2434 W. BELVEDERE AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?.

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) SCULPTOR ART 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN UNKNOWN MATA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1209 N. CHARLES ST., APT. 208, BALTIMORE, MD 21201 SHARON HANDEL/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
ARLINGTON CHIZUK
AMUNO CEMETERY 1 X Burial 2 Cremation 3 Removal from State 04/12/2012 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Nist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 SCHEMIC Priysician/ CARDIOMYOPATHY disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** NUESTIVE MILURG Sequentially list conditions, Examine Due to lut as a consequence of ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and s the burial-transit CORONARY SISEASE Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 5 Residence 6 Other (Specify) 1 Inpatient 2 X ER/Outpatient 3 IDOA ပ္ within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral i 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural
Accident
Suicide
Homicide (Month, Day, Year) Hospital or Attending 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioners To the best of my knowledge, de red at the time date and plane, and due to their 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) PHYSIGAN DO064533 04/10/2012

State Registrar APR 1 8 2012

NNDE

AJANIM) 2434 W-BEZVEDERE AVENUE BALTMORE MUZIZIS

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEVINDALE - MEBREW GERIATRIC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1,10e&19b Per PHY&FH G927 5/01/2012 JH State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar 12034 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ∧ Month Physician/ Don Ulysses Harris Medical 4a. Facility Name (if not institution, give street and number)
University of Maror Location of Death 4c. County of Death Examiner ONT an 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Months Hours Min (Month, Day, Year) 1 🛣 M 2 🗆 F Director 220-54-5308 61 09/07/1950 MARYLAND Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits 10c City Town or Location with the Maryland notified at **Funeral Director** 28a-f 1 Yes 2 X No MD HARFORD ABERDEEN 10e. Street and Number **Windemere** 10f. Zip Code 5 10g. Citizen of What Country? ms 23a or must be n 522 WINDELERE DR 21001 U.S.A. Firmt. Page 1 and 2 should be filed within 72 hours after death to preferent of Health and Mental Hygiene. Fortant: If item 27 is marked other than "natural", or items by injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Force Black, White, etc. þ 1 Never Married 2X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify 3 Widowed 4 Divorced Completed BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 DISABLE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ RALPH MURRY EVELYN C. HARRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Windemere CAROLYN NUTTER HARRIS/WIFE 522 DR. ABERDEEN. MD21001 Inportment of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Dopation 5 Other (Specify) CEMETERY 04-21-2012 DARLINGTON, MD BERKLEY e of Funeral Service Li WILLIAM C. BROWN COMMUNITY FUNERAL HOME HARFORD PA 321 S. PHILADELPHIA BLVD. ABERDEEN, MD 21001 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ umonic Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 . Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by on home 1 Yes 2 No 3 Probably 4 Unknown rolonged 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy After this certificate has completely filled in by the funeral director, page 2 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient 2
Date of injury Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 2 L 1 🗌 Yes Certificate: To ER/Outpatient 3 DOA Manner of De Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only en the within To the 29b. Signature 29c. License number 29d. Date signed (Month. Day. Year) Marylan Name and Date filed (Month, Day, Yea Green

DHMH 17 Rev 06-2011

State Registrar 32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylar		artment of F tificate of D		lental Hyرا ا	Reg. No 20	12 12035
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ith	3. Time of Death
~,	Medic	al	MORRIS 4a. Facility Name (if not institution, give st	reet and number)		I SMART 4b. City, Town, or	APRIL	15 20 4c. County	012 06:15P M	
)	Examin	er	GILCHRIST HOSPICE			TOWSON	Location of Boats		BALT	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day		Birthplace (State or Foreign Country)
	Director		215-01-5730 1 X Usual Residence of Decedent	M 2 □ F	93 Yrs.			01/27	/1919	MD
	yland f shoved at	stor	10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	r 28a- notifi	Direc	MD CARROLL 10e. Street and Number	SY	KESVIL	LE 10f. Zip Code			10g. Citizen of V	1 Yes 2 X No
	with th	Funeral Director	7105 NORRIS AVEN	UE		21784			Tog. Offizer of v	USA
	death items ner mu		11. Marital Status	Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian, ck, White, etc.
36	after al", or Exami	d by	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates.	1	I ☐ Yes 2 🏋 No	Specify:		Specify:	
2-00	hours 'natur dical B	olete	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	dent's Usual Occupa	ation	ina	16b. Kind of Bu	usiness/Industry
21215-0036	e filed within 72 hours after death with the Maryland thal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. D	O NOT use retired) OUALITY	ASSURANC		FFDFR	AL GOVERNMENT
1d 2	iled wi I Hygie other ent, ti	Be	17. Father's Name (First, Middle, Last)			QUILLII	18. Mother's Nam			
ylar	should be filed and Mental Hy is marked oth aumatic event	ပ္	LOUIS		ISMART		JENNIE			STEINBERG
Maryland	1 and 2 should be f Health and Men item 27 is marke other traumatic	17	19a. Informant's Name/Relationship (Type		T	ng Address (Street a				
	f Health item 27 other tra		JACQUELINE HILLMA 20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of		Date		- City or Town, State
altimore,			1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			natory or other plac AI CEMETE		7/2012	OWING	GS MILLS, MD
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licenses		22	. Name and Addres	s of Facility SO	L LEVIN		ROS., INC. LLE, MD 21208
			23a. Part 1. Enter the disease, or compli- shock, or heart failure. List only one	cations that caused the dear	th. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Physician	F 10	Immediate Cause (Final disease or condition resulting in death)	Melano	mA					Onset and Death
7	Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):					
	cuted ind transit	Examiner	Cause (Disease or injury that initiated events	. Duals for an account						
	cate be executed physician and sthe burial-transit	edical E	resulting in death) Last	Due to (or as a conseq	derice oi).					
68760	ficate g phys as the	Medi	TEETHALE.							
39 X	death certificate be executed the attending physician and ed for use as the burial-transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of pregnant 1 Live Birth 2 Fet	al death 3		у			ate of delivery
. Box	ss that the death igned by the atte be detached for	ysic	1 Yes 2 No 9 Unknown	4 Pregnant at time of 9 Unknown	death 5 L	Other (specify)				July Tour
P.0	that the	by Pi	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	ınderlying cause giv	en in Part I.	23e. Did to	bacco use conti	ribute to the cause of death?
rds,	v requires that is been signed to should be det	eted						1 🗆 '		3 Probably 4 Unknown
of Vital Records,	The law requires that the ate has been signed by the page 2 should be detach	Completed						24a. Was autop perfo	rmęd?	Were autopsy findings available prior to completion of cause of death?
al R	sician: The law of certificate has be lirector, page 2 s	Be Co	25. Was case referred to medical			26. Pla	ace of Death (Chec		2 No	1 Yes 2 No
Vit	> 0 0	은	1 L Yes 2 DVNo	ospital:			4 ☐ Nursing Ho		lence 6 X Othe	
n o	iding F th. After funer	cate:	27, Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work	/ at ? Yes 2 □ No	28d. Describe h	ow injury occurre	ed •
>	I or Attending after death. Director: After I in by the fune	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif		eet, factory, office		28f. Location (S City or Tow		er or Rural Route Number,
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thin completely filled in by the funeral	Medical		ian: To the best of my knower: On the basis of examination						ner as stated. e to the cause(s) and manner stated.
	o the vithin 2 or the comple	ž	only one) 3 L Certifying Nurse 29b. Signature and title of certifier	Practitioner: To the best of	my knowledge	, death occurred at the 29c. License				manner as stated. d (Month, Day, Year)
			> Cfaralr	ベ)		0	58303	/	APRIL	16 2012
	6 4		30. Name and address of person who con	HAMES 1	M) (Print) = 701 N	Chris	Lu ST	Tous	ion mg
4.3	Sta Registra		APR 1 8 2012	32. Registrar's \$ and	ature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 12036 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 0508(AM 201 1997 Johnson P Medical 4a. Facility Name (if not institution, give street and number) County of Death City, Town, or Location of Death Examiner Raltmore Maryland more fear If Under 24 Hrs 8. Date of Birth Birthplace (State of Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Months Hours 07-18-46 SC 248-94-3182 65 Director 1 🖾 M 2 🗆 F Yrs. Usual Residence of Decede 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location ŧ 10a. State with the Maryland Director ms 23a or 28a-f s must be notified Baltimore 1XXYes 2 No NA MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number **USA** Funeral 21223 308 N. Carrollton Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 XXNo
If Yes, Give
Year or Dates. Black, White, etc. African 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after Specify: American 1 Yes 2 No Specify Completed 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. Iom 27 is marked other than ' Elementary/Secondary (0-12) Construction Laborer 8th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pressly ပ Glayes Willie Johnson traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traulonce. 2573 W. Fayette Street Baltimore, Maryland 21223 Queen E. Jackson-Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Mt. Zion Cem. 1 X Burial 2 Cremation 3 Removal from State Lansdowne, MD 04 - 21 - 124 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ voscieniti disease or condition Medical resulting in death) Due to (or as a conseque ce of) Examiner ears Sequentially list conditions, Due to or as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy Į, in the past 12 months? Pregnant at time of death 5 Other (specify) igned by the at be detached for 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page 2 death? after death.

Director; After this certificate Yes 2 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation iniury Natural 2 🗌 No Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

within 24 hours a

To the Funeral C

completely filled

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 = only one) 29b. Signature and title of certifie 29c. License number Date signed (Month, Dav. Year) me and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	State of Maryland						12027
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of D	Death	Re 2. Date of Death	g. No. 2012	
	sicia: Medic	al .	John Louis Jeddry Jr	•			April	[□] f³3 2˙0°	3. Time of Death 10:45 %
Ex	amine	er	4a. Facility Name (if not institution, give street and number) Gilchrist Center			Location of Death		4c. County of Dea	imore
Dire			5. Social Security Number 6. Sex 7. Age (In yrs. las 219-38-3280 1 X M 2 F 71	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Dec • 21	(ear) 9.8i	rthplace (State or Foreign ountry) MD
laryland 3a-f show	ified at	ector		Town or Loc	cation .ddle Ri	ver			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
with the M	ust be not	Funeral Director	10e. Street and Number 31 MAxa Court		10f. Zip Code	1220	10	og, Citizen of What C	ountry?
21215-0036 within 72 hours after death with the Maryland gigne. er than "natural", or items 23a or 28a-f sho	or other traumatic event, the Medical Examiner must be notified at	ह	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates.	If	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2X No	n, Mexican, Puerto		14. Race - Am Black, Whi	
Baltimore, Maryland 21215-0036 cernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o	the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11th	(Give k	dent's Usual Occupa kind of work done d O NOT use retired) Cal Tech	luring most of work	ing	Ob. Kind of Business Dentis	
land 2 be filed w ental Hygi ked othe	ic event,	as F	17. Father's Name (First, Middle, Last) John L. Jeddry Sr.		-		e (First, Middle, Ma		
Maryland 12 should be file Ifth and Mental I 27 is marked o	r traumat		19a. Informant's Name/Relationship (Type, Print) Ann Jeddry /wife	19b. Mailin				City or Town, State, Z	
Baltimore, Maperinit. Page 1 and 2 st Department of Health a Important: If item 27 is	y or other		1 X Burial 2 Cremation 3 Removal from State	metery, cren	esition (Name of matory or other plac of Fai	e) !		Rossvil	
Baltin permit. P Departm Importar	any injur once.		21. Signature of Europe Service Tensee		2. Name and Address	ss of Facility 30	0 MAce	Ave. Bal	lto. MD
- Physic			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	F 0	er the mode of dying				Approximate Interval Between Onset and Death
	dical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or at a consequence)	ence of):	meev_				
⊕' ½ _	ınsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):					8
60 steep the steep of the steep	ne burial-tra	dical Ex	that initiated events resulting in death) Last C. Due to (or as a conseque	ence of):					
Box 687 death certifics he attending p	detached for use as the	₩	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown 23c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnand Other (specify)	у		23d. Date of d Month	elivery Day Year
Is, P.O. uires that the n signed by the	oe d	ρ	Part II. Other significant conditions contributing to death but not resu	Iting in the u	underlying cause giv	ven in Part I.			to the cause of death?
Division of Vital Records, tal or Attending Physician: The law requires its after cleath. In Director: After this certificate has been significate than the control of the	page 2 should l	Completed					24a. Was an autopsy perform	y prior to ned? death?	utopsy findings available completion of cause of es 2 No
ital sician: certific	irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: I postiont 2 F		_ Oth	ace of Death (Chec		- May	city Hospice
n of V ding Phy: th. After this	funeral d	cate: To	1 Linpatient 2 Lie	28b. Time of injury	28c. Injury work	y at	28d. Describe hov	nce 6 🖾 Other (Spe w injury occurred	city) the day
ivisio l or Atten after dea Directors	d in by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)		eet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate ha	oletely fille	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowle only one) 3 Certifying Nurse Practitioner: To the best of my knowle	and/or invest	tigation, in my opinio	on, death occurred a	it the time, date and	d place, and due to the	e cause(s) and manner stated.
To th withir To th	сош	-	29b. Signature and title of Pertifier Signature and title of Pertifier		29c. License	number 139	29 J	9d. Date signed (Mon	th, Day, Year)
14	0		30. Name and address of person who completed cause of death (Item: SYED Q. ABBAS 6701 N Class	23a) (Type, F				MD 2120	,4
Re	Stat gistra	e ır	31. Date filed (Month, Day, Year) APR 1 8 2012 APR 1 8 2012	ire					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	te or waryland /		ificate of D		vicitai riy	Bea No -		
		,	Decedent's Name (First, Middle, Last)					2. Date of Dea		12	3. Tirke of Death 8
Н	Physicia Medic		Terry L. Jenkins	5				April	15 20	Year 2 1 2	12:21Рм
The same of the sa	Examir	er	4a. Facility Name (if not institution, give street and				Location of Death	W. Patricia		y of Death	
4			Carroll Hospital 5. Social Security Number 6. Sex		Code of a CA	Westn If Under 1 Year	ninster If Under 24 Hrs.	Lonicati	Carı		
	Funeral Director		212-62-4638 5. Sex	7. Age (In yrs. last b	1	Months Days	Hours Min.	8. Date of Birt (Month, Day	h y, Year) 3-1952	Count	lace (State or Foreign try)
			Usual Residence of Decedent		Yrs.			10-23	1952	MD	
	yland f shc ed at	ioi.	10a. State 10b. County MD Carroll	10c. City, To	wn or Loca		minster			1	0d. Inside City Limits
	e Mar r 28a notifi	Director	10e. Street and Number				minster				1 Yes 2 No
	/ith th	ral	11 Kalten Rd.			10f. Zip Code	1158		10g. Citizen of USA	What Coun	try?
	ems ems	Funeral	11. Marital Status 12. Was	Decedent Ever in U.S.	13. Wa			ecify Yes or No-		ce - America	an Indian
9	fer de smine	þ	1 ☐ Never Married 2 ♣ Married 1 ☐	ed Forces? Yes 2 XNo	1		spanic Origin? (Spo n, Mexican, Puerto	Rican, etc.)	Bla	ck, White, e	etc.
003	urs af tural" al Exa	ted	3 Li Widowed 4 Li Divorced Year	s, Give or Dates.	1 L	Yes 2 X No	Specify:		Specify	/:whit	e
15-	e filed within 72 hours after death with the Maryland tital Hygiene. So other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade comp	(eted)	(Give kin	nt's Usual Occupa nd of work done d NOT use retired)	ation Juring most of work	ing	16b. Kind of E	lusiness/Inc	dustry
212	vithin jene. er tha the N		Elementary/Secondary (0-12) Colle 12	ege (1-4 or 5+)		lder			Constr	ructi	on
pu	filed val Hyg	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sumam	ie)	
ylaı	should be filed within 7 and Mental Hygiene. is marked other than aumatic event, the M	욘	Nathan F. Jenkins	5			Jean E	. Grim	ım		
Maryland 21215-0036	- G - G		19a. Informant's Name/Relationship (Type, Print)		-		nd Number or Rura			. ,	· ·
	and 2 s Health tem 27		Ethel B. Jenkins-w 20a Method of Disposition			alten R	d.,West				
Baltimore,	0		1 Burial 2 Cremation 3 Removal	from State ceme	tery, crema	tory or other place	e)	Date	20c. Location	-	·
İţi	permit. Page Department Important: any injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature/of Funeral Service Licensee / / /	Souti			rem $4-1$				
Bã	permi Depar Impor any ir	J.	I Showed D. Father	In III			ain St.				
П			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one caus.	that caused the death. Do							Approximate
	Physician/	7 10	Immediate Cause (Final disease or condition		mmy 1.	msculm	die		Interval Between Onset and Death		
	Medical Examiner		resulting in death) aa.	e to (or as a consequence					01. 70.		13 905
		er	Sequentially list conditions, b.	co to Distance was seen about the	in this c					_	
	ed nsit	Examiner	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e to (or as a consequence	a cij.						
30	execut in and ial-tra		that initiated events c	ie to (or as a consequence	e of):						
8760	ificate be executed ig physician and as the burial-transit	Medical	d								
876	rtifical ing ph e as th		IF FEMALE:	1000					1		
9 X G	ith cert	Physician/I	23b. Was decedent pregnant 23c. If yet in the past 12 months?	s, outcome of pregnancy Live Birth 2 Fetal dea		ctopic pregnancy	/			ate of delive	
	the atter	ysic		Pregnant at time of death Unknown	1 5∐(Other (specify)			IVIC	лип	Day Year
Division of Vital Records, P.O.	The law requires that the death cert ate has been signed by the attendin page 2 should be detached for use	by Ph	Part II. Other significant conditions contributing	to death but not resulting	g in the und	erlying cause give	en in Part I.	23e. Did to	bacco use cont	ribute to the	e cause of death?
S,	uires t n sign uld be		dystopodnia					1 🗆 🗎	res 2 🔼 No	3 🗌 Prob	ably 4 🗆 Unknown
örc	w requires bee	Completed	His out tens. m					24a. Was a		Were autop	sy findings available
Rec	The law ate has page 2	Com						autop perfor 1 Yes	med?	death?	npletion of cause of
ta	ysician: The is certificate director, pag	Be (25. Was case referred to medical examiner?			26. Pla	ce of Death (Check				
έ	S S ID	1		1 Inpatient 2 KER/C			4 L Nursing Ho				
n o	Jing After fune	cate	1 Natural 5 Pending	Date of injury (Month, Day, Year)	Time of injury	28c. Injury work? M 1 🔲 N		28d. Describe h	ow injury occurr	ed	
isio	Atten r deal sctor: by the	Certificate:	3 Suicide 6 Could not be	Place of Injury - At home, t	farm, street		165 2 110	28f. Location (S	treet and Numb	er or Rural	Route Number.
Div	s after s after s al Direction		4 El Hollinoide	ouilding, etc. (Specify)			ļ	City or Town			
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	Medical	29a. Certifier (Check Medical Examiner: On the	the best of my knowledge	e, death occ	curred at the time,	, date and place, at	nd due to the ca	use(s) and man	ner as state	d.
	To the H within 24 To the F complet	Me	only one) 3 L Certifying Murse Practiti	oner: To the best of my kn	owledge, de	eath occurred at th	e time, date and pla	ice, and due to th	ne cause(s) and r	manner as st	ated.
	7 Wit		29b. Signature and title of certifier	. 111		D335			29d. Date signe 4 – 1 7 – 2		ay, Year)
			30. Name and address of person who completed	and the same of th	(Time De'						
	10			ky, 125 Ai			Ste. 3	4, Wes	tminst	er,M	D 21157
	Stat			32. Registrar's S				-			
*	Registra	ır	W. 11 - O VORDON								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month XAVIER 2012

Baltimore

Months

7. Age (In vrs. last birthday)

83

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

Days

04:27 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 X Yes 2 □ No

Maryland

White

21206

Approximate Interval Between Onset and Death

Day

3 Probably 4 Unknown

2 🗌 No

4940 Eastern Avenue, Baltimore, MD, 21224

County of Death

8. Date of Birth (Month, Day, Year)

Jan. 10,1929

N/A

Physician /Medical Examiner

1 - For State Registrar

5. Social Security Number

217-24-5785

4a. Facility Name (If not institution, give street and number

Johns Hopkins Bayview Medical Center

6. Sex

1 🔀 M 2 🗆 F

Funeral

Director 28a-f show notified at ò Examiner must be 23a death v items ? Pages 1 and 2 should be filed within 72 hours after ò 'natural", the Medical al Hygiene. traumatic event, and Mental H Health a Department of Healt Important: If Item 2: any injury or other I

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

permit.

physician and Box 68760. The law requires that the death certificate be use as attending signed by the at P.O. Division of Vital Records. has Hospital or Attending Physician: this After death Director: A

Usual Residence of Decedent 10b. County 10a State 10c. City. Town or Location Director N/A Baltimore City MD 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 4506 Shamrock Avenue 21206 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Korean Year or Dates: Korean 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Local 101 Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clementina Bruni Albert Jeannetta ပ 19a. Informant's Name/Relationship (Type. Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Lucille Joann Jeannetta 4506 Shamrock Ave. Baltimore, Maryland 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Garrison Forest V.A. Cem. 4/20/2012 Owings Mills, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Neiser Duda-Ruck Funeral Home of L 7922 Wise Ave. Dundalk, Mar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 7922 Wise Ave. Dundalk, Maryland 21222 shock, or heart failure. List only one cause on each line. Immediate Cause (Final ATHEROSCIEROTIC VASCILLAR DISEASE a.ACUTE disease or condition resulting in death) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine (or as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 2 ER/Outpatient 3 🗌 DOA 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending investigation (Month, Day Year) Injury 1 Yes 2 No 2 Accident 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29b. Signature and title of certifier 10063303. 30. Name and address of poson who completed cause of death (Item 23a) (Type, Print)

State Registrar Redich

31. Date filed (Month, Day, Year) .

DHMH 17 Rev 1/2001 11595

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within 24 hours a

To the Funeral C

completely filled

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas	se Type or	Print	in Bla	ack Ir	ndelible	lnk	c. Ensure /	All Copie	s Ar	e Legi	ble.	
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Physicia Medic		John	VT	. Joi	INS	ON					2. Date of De Month		lay	Year 2	3. Time of Death
Examin	er	4a. Facility Name (if								Location of Death			County of		
Funeral		5. Social Security N		al Center		ı yrs. last t	birthday)	Westm If Under 1 Y	ear	If Under 24 Hrs.	8. Date of Bi	rth	Carro	g. Birth	olace (State or Foreign
Director		218-36-19 Usual Residence		1 X M 2 □ F	72	<u>.</u>	Yrs.	Months Da	ays	Hours Min.	03/07			Coun	(try) (1D)
yland f sho	ctor	10a. State	10b. County		10		own or Loc							1	0d. Inside City Limits
r 28a	Funeral Director	MD 10e, Street and Nun	Carro	011		West	tmins	iter 10f. Zip Cod	40			10- 0	Citizen of W	thet Cour	1X Yes 2 No
with th	eral	1828 Old		own Road				211.					JSA	nai Cour	itry :
leath v	Fun	11. Marital Status	Tarkey	12. Was Dece Armed Fo	edent Ever	in U.S.	13. V	Vas Decedent	of His	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No		14. Race		an Indian,
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	1 ☐ Never Marr 3 ☐ Widowed		ed 1 Yes If Yes, Giv Year or Da	2 X No			Yes 2X			nican, etc.,		Specify:	k, White, Whate, Whate, Whate, White,	etc. nite
n 72 hou an "natu Medical	Completed			t grade completed)	1 or 5.)	1	(Give k	lent's Usual Ockind of work do O NOT use reti	ne d	ation luring most of work	king	16b.	Kind of Bu	siness/In	dustry
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should and ∿ is ma auma	Ì	19a. Informant's Na	ame/Relationshi	ip (Type, Print)		1	I9b. Mailin	g Address (Str	eet a	nd Number or Rur	al Route Numb	er, City o	or Town, St	ate, Zip (Code)
and 2 Health Sm 27 Sher tr		Elizabet		rne/wife						ytown Ros					21157
age 1 a		1 Burial 2	☐ Cremation	3 Removal from	State	ceme	etery, crem	sition (Name or natory or other	place	' !	Date		Location -		
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permi Depar Impo any ir		1/2.	ce/-	utt	1					ngton Roa					21157
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months? ☐ No	23c. If yes, out 1 Live 4 Preg 9 Unkr	Birth 2 🗀 nant at tin	Fetal de	eath 3 🗆	Ectopic pregi Other (specifi		у			23d. Date Mon		ery Day Year
that the	by P	Part II. Other signif	icant condition	ns contributing to d	eath but n	not resultin	ng in the u	nderlying caus	e giv	en in Part I.	23e. Did	tobacco	use contril	bute to th	ne cause of death?
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e Hospita 124 hours e Funeral	Medical	(Check 2	Medical Ex	Physician: To the b caminer: On the bas Nurse Practitioner	is of exam	nination and	d/or invest	igation, in my o	pinio	n, death occurred a	t the time, date	and plac	e, and due	to the car	use(s) and manner stated
To th within To th comp	<	29b. Signature and		2/40	a	n		29c. Lic	ense	number		29d. D	ate signed	(Month, i	Dav. Year)
101		30. Name and address	ess of person w	po completed caus	se of death	n (Item 23	a) (Type, P	rint) Back	na	in ct	We if	200	usto.	, M	0 24157
Stat		31. Date filed (Month	<u>, </u>		egistro 's	Signa ure	March 1	- 1/ >/		-11. 71	VV C.3/	,,,,,		-	•

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 12041 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O4 Day Year 10:30AM ames 2 12

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

1 - For State Registrar

Physician

/Medical Examine

Funeral Director

Physician /Medical Examiner

> use as the burial-transit To the Funeral Director: Alter this cartificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-trar within 24 hours after death. To the Funeral Director: After

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

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	5. Social Security N	"(tunk)" 1	2 M 2 □ F	54	,	Months Days		Min.	(Month, D	ay, Year)	Cou	vland
	Usual Residence of	Decedent		J- /		J			OTT	2017	Do I	laı	yrand
	10a. State	10b. County		10c. C	ity, Town or L	ocation							10d. Inside City Limits
jo	Md.				Baltin	nore Cit	У						1 ⊠ Yes 2 □ No
lec	10e. Street and Nur					10f. Zip Code				10g. C	itizen of Wha		intry?
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ete	(Spec	15. Decedent's Ed ify only highest gra	ucation de <i>completed)</i>		16a. Dece	ident's Usual Occu is kind of work done DO NOT use retire	pation during most	of workir	ng	16b. i	Kind of Busin	e <i>s</i> s/lr	ndustry
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 0	27. Manner of Deat	h 5 ☐ Pending	28a. Date o (Month	f Injury n, <i>Day Year)</i>	28b. Time Injury	W			28d. Describe	how inj	ury occurred		
cat	2 Accident 3 Suicide	investigation 6 Could not be					Yes 2 n			(0)			-10
E	4 Homicide	determined	286. Place	of Injury - At ig, etc. (Spec	home, larm, s	treet, lactory, office		1	City or To	(Street a own, Sta	te)	or Hu	ral Route Number,
<u>ဒီ</u>	20a Cartifies	15 Cartifuina Dh	veision. To the	hast of my le		th		d alaaa .	and due to the		-1 and	01.00	etated
edical Certification	29a. Certifier (Check only one)	☐ Certifying Ph 2☐ Medical Exen	ysician: 10 the niner: On the ba and mann	sis of examin	nation and/or i	nvestigation, in my	opinion, deat	th occurr	ed at the time	, date a	nd place, and	due	to the cause(s)
Mec	29b. Signature and	title of certifier				29c. Licer	ise number			29d. D	ate signed (/	Month	, Day, Year)
	Ge	dion	Atnof	-	M-D	Do	062	148		6	1140	21	2012
	30. Name and addr	ess of person who	completed cause	e of death (Ite	em 23a) (Type						, (,		
	GEDION					ewood p	d 18	720	Glen	Bu	rnie	M	0 21061

W

State Registrar

GEDION 31. Date filed (Month, Day, Year

amend 8, per fh, g927 5-4-12 sm

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#8, 20C, perff, G926, 4/18/2012, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12 /Medical Facility Name (If not institution, give street and number) 4c. County of Death Examiner Kandaustor 118815 Stor ML 8. Date of Birth / 16 (Month, Day, Year) 5 Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Months 1 M 2 □ F 3/6-14-7358 Usual Residence of Decedent Yrs. 87 Director 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show at notifled 1 □ Yes 2 No BALTIMORE RANDAIISTOWN Funeral Director 10g. Citizen of What Country? 10e. Street and Number ms 23a or 01133 U.S.A. BERTI death 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner man 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 2 No 6/1943 filed within 72 hours after 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Specify: BLACK altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Be Completed by 3 Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRANSPOR TATION 12 TRUCK DRIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ant of Health and Mental Hit: If Item 27 is marked oth y or other traumatic eventy Pages 1 and 2 should be c CARGO COLIE THOMAS KEENE ပ (Type. Print) 19a. Informant's Name/Relationship 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 🛛 スノススタ PATRICIA EPPS 20a. Method of Disposition Apt. B, BALLIMORE, MARYLAND DAUGHTER Owings Mills, Maryland 1. Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any Injury or 23 2012 Oldings Mill SARRISON FOREST CEME. 4 Donation 5 Other (Specify) 22. Name and Address of Facility FE DERRICK C. JONES F/H, P.A. 21. Signature of Funeral Service Licenses PARK HGIS. AUE., BALTIMURE, MARVIAND 4611 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications hat shock, or heart failure. List only one cause on at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Immediate Cause (Final disease or condition resulting in death) Physician Sta /Medical Due to g r as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) P.O. Box 68760, physician attending property for use as use IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2**X** No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2 NO or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 100 Other: 1 ☐ Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Dinatural 2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) Injury М 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Y ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title; of certifier 29c. License number 29d. Date signed (Month, Day, Year) Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 12043 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ APRIL 13 2012 Year 10:38A M WILLIAM KRAMER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HARFORD **UPPER CHESAPEAKE** BEL AIR 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours (Month, Day, Year) 217-26-7942 80 Director 1 🗶M 2 🗆 F MARYLAND 10-24-1931 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD HARFORD **JOPPA** 10e. Street and Number 10g. Citizen of What Country? items 23a or 10f. Zip Code Funeral 2311 BEVERLY DRIVE 21085 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces?
Yes 2 \(\sum \) No Black, White, etc. ò ģ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: "natural" Completed 3 Widowed 4 Divorced Specify. WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working than Elementary/Secondary (0-12) 12TH life. DO NOT use retired) College (1-4 or 5+) **ELECTRICIAN** CHEMICAL COMPANY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ EDWARD G. KRAMER MARY A. MAGNESS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALLYNE KRAMER **SPOUSE** 2311 BEVERLY DRIVE JOPPA, MD. 21085 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State ATLANTIC CREMATORY 4-18.2012 GLEN BURNIE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME INC. re of Funeral ervice lensee 610 W. MACPHAIL ROAD BEL AIR, MD. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Caro Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical ramer, Willia Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CABG CAD PE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deal Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the I

complete Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ferm; n Barryeto Sr. mo 5000 pper chescipeate Drive Belfir Mp 21014

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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		Registrar 1. Decedent's Name (First, Middle,	Last)	-		tificate of L	Jeann	2.	Date of Death	eg. No. 20	14	3. Time of Death
Physicia Medic			Gloria		E. Ke	llner			Month April		2ÖÏ'2	12:20 AM
Examin		4a. Facility Name (if not institution,		,		4b. City, Town, or				4c. County		re Co.
Funeral		Manor Care Ross 5. Social Security Number	6. Sex		yrs. last birthday)	If Under 1 Year	ssvill If Under 24	4 Hrs. 8.	Date of Birth		9. Birthp	lace (State or Foreign
Director		220-36-7842	1 □ M 2 🛣 F	71	Yrs.	Months Days	Hours	Min. J	uly 7,	1940	Mar	yland
and show	or	Usual Residence of Decedent 10a. State 10b. County		10	Oc. City, Town or Lo	cation					1	0d. Inside City Limits
Maryla 28a-f	Director	MD Ba	altimore					В	Baltimo	re Co.		1 🗌 Yes 2 ី No
ith the 3a or it be n	ral D	10e. Street and Number	A			10f. Zip Code 21 2 24	<i>t</i> .		10	Og. Citizen of N United		-
eath w tems?	Funeral	7420 Belmont 11. Marital Status	12. Was Dece			Vas Decedent of Hi	spanic Origin	n? (Specify	Yes or No-		e - Americ	
after d	by	1 Never Married 2 Marrie	Armed Formed 1 Yes If Yes, Given	2X No		Yes, specify Cuba		Puerto Rica	an, etc.)		ck, White, e	
A 13-005 n 72 hours aft en "natural", Medical Exal	letec	3 Widowed 4X Divorced 15. Decedent	Year or Da 's Education	ates.		ent's Usual Occup				16b. Kind of B	whit	
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Midt.		19a. Informant's Name/Relationshi				g Address (Street a 2 Se1win						1237
Desirinity of and 2 should be filed within 72 hours after death with the Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hyglene. Department of Health and Mertall Hyglene. Inmportant: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition A Burial 2 Cremation 3 4 Donation 5 Other (Sp		State	20b. Place of Dispo cemetery, cren Oak Lawn	natory or other plac	e) 4/	Date 16/20		Poc. Location -	-	wn, State Maryland
permit. Page 1 Department of Important: If is any injury or or once.		21. Signat of Funeral Service Lice		9		Name and Address uda-Ruck 922 Wise	s of Facility Funer	al Ho	me of	Dundall	k, In	с.
		23a. Part 1. Enter the disease, or o shock, or heart failure. List on	omplications that of	caused the								Approximate Interval Between
Physician/	2.74	Immediate Cause (Final disease or condition	a		Cor	Pulmon	MALE				- 4	Onset and Death
Medical Examiner	L	resulting in death) Sequentially list conditions,	Due to	or as a co	onsequence of): SEVER	E RIE	MT M	EART	FAIL	URE		
ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Duato	(or as a co	nisequence of):	A SCV	D					
cate be executed physician and the burial-transit is the burial-transit.	dical Ex	resulting in death) Last	Due to	orasaco	onsequence of):							
rtificate ling phy e as th	/Med	IF FEMALE:	00-15									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Birth 2 [nant at tin	Fetal death 3	Ectopic pregnanc Other (specify)	у			23d. Da	te of delive nth	ery Day Year
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The law require	Completed								24a. Was an autopsy perform	ed?	prior to con death?	osy findings available inpletion of cause of
ysician: The ysician: The lis certificate director, pag	Be C	25. Was case referred to medical examiner?	11			26. Pla	ace of Death	(Check onl	1 Yes 2 ly one)	M No.	I ☐ Yes	2 □ No
Physic Physic this ce al dire	유	1 ☐ Yes 2 ☑ No 27. Mann of Death	Hospital: 1 28a. Date		2 ER/Outpatien		4 Wurs		5 Resider			
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To the Hospital or Attending Phywithin 24 hours after death within Ethoren Director. After this completed filled in by the funeral.	Medical	(Check 2 ☐ Medical Ex only pre) 3 ☐ Certifying N	a miner: On the bas	is of exam	knowledge, death on nination and/or invest t of my knowledge, o	igation, in my opinio	n, death occu	urred at the	time, date and	place, and due	to the cau	se(s) and manner stated.
To with		29b. Signature and title of certifier	/			29c. License	number -727		29	d. Date signed	(Month, E	ay, Year)
p		30. Name and address of person w	ho completed caus	1 8		man l	160d	Is Rux	ad. 1	402	123	7 -
Stat Registra		31. Date filed (Month, Day, Year) APR 18	2012	egistiar's	Signatur Ada	alal						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 12045 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2,2012 8:57PM Irene Jane Kirtscher April Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Ctr Bel Air If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months 0876671927 Delaware **Director** 214-24-8067 85 1 M 2 XF 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 28a-f 1 Yes 2 No Maryland Harford Havre de Grace o 10f. Zip Code 10g. Citizen of What Country?
United States of Funeral items 23a 1111 Revolution Street 21078 America 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 😾 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Family Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of Nicholas Shatynski Maria Marcinyshyn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a 1111 Revolution St, Havre de Grace, MD 21078 Allen Kirtscher, III (son) Department of Healt Important: If item 2 any injury or other i 20a. Method of Disposition 20c. Location - City or Town, State Havre de Grace, 20b. Place of Disposition (Name of cemetery, crematory or other place) 04/18/2012 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Angel Hill Cemetery Maryland Signature of Fune al Service Libers 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S. Washington St. Havre de Grace, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending for use as IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \sum Yes 2 \sum No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred the Hospital or Attending Natural Accident 5 Pending injury Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. within 24 hours a

To the Funeral D

completely filled Medical 29a. Certifier rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Tertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20053568 12 pril 12, 2012

State Registrar 30. Name and address of person v

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completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 12046 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 06:14A M APRII 2012 ZELDA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST OF COLUMBIA HOWARD COLUMBIA Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min (Month, Day, Year) Director 216-20-6542 1 □ M 2 🗓 F 84 10/11/1927 MD 28a-f shov 10b. County 10c. City, Town or Location 10d, Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No BALTIMORE BALTIMORE 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6 BARBICAN WAY 21208 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b, Kind of Business/Industry giene. life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) U.S. GOVERNMENT SECRETARY should be filed with and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ KAUFMAN FALK HANNAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trauone. 12113 HENESON GARTH, OWINGS MILLS, MD 21117 SHELLEY ROSENTHAL / DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ANSHE EMUNAH — ATTZ CHATM 1 X Burial 2 Cremation 3 Removal from State 04/16/2012 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur 22. Name and Address of Facility SOL LEVINSON & BROS., INC MD 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final . h, si∷ian disease or condition resulting in death) METOSTATIC OCCUMENTING Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): and -tran. that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a thed for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes No Day Pregnant at time of death Unknown g Unknown P.0. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I by Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has performed? Yes 2 No certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 200 No Other: 4 ☐ Nursing Home 5 ☐ Residence Other (Special ျ 1 Inpatient 2 ER/Outpatient 3 DOA After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending ☐ Accident ☐ Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 only one 29b. Signature and title of certifier

Registrar

APR 182012

edocione

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar 12047 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JEAN KIRSH APRIL 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7203 ROCKLAND HILLS DRIVE, BALTIMORE BALTIMORE Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Hours Min (Month, Day, Year) Director 214-24-6018 1 🗆 M 2 🗓 F 83 10/19/1928 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD BALTIMORE BALTIMORE 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 7203 ROCKLAND HILLS DRIVE, #212 21209 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced Specify. WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) **SECRETARY** BANKING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ BENJAMIN **GENDASON** ELZA OPPENHEIM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARROLL KIRSH/HUSBAND 7203 ROCKLAND HILLS DR. #212. BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM 04/15/2012 REISTERSTOWN, MD Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Malt 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician Cancer disease or condition resulting in death) YKAIS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a echasquenes of). If any, leading to immedicause. Enter Underlying Cause (Disease or injury requires that the death certificate be executed -tran and that initiated events resulting in death) Last Due to (or as a consequence of): physician are the burial-t Physician/Medical as the attending IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director: After this certificate has b page 2 autopsy performed? Yes 2 Wo prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) NOSD LC 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at eral Director: After filled in by the funer 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 12 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UV HARLES AMON (M) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 For State Registrar 12048 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 4, Physician/ Lenora 2012 Kelly April 6:50 $\mathbf{A}\mathbf{M}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Homewood Center Baltimore If Unde Months 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours April Day (Month 1940) Director 1 □ M 2 🛚 F USA 220-38-6419
Usual Residence of Decedent Yrs Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Waldorf MD Charles 10f. Zip Code 20603 10e. Street and Number 10g. Citizen of What Country? Funeral 4387 Eagle Court Apt. 906 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White etc. Black þ ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Nurse s Aide 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Health Be 18. Mother's Name (First, Middle, Maiden Surname) Helen Melton 17. Father's Name (First, Middle, Last) Deroy Thornton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4387 Eagle Ct. Apt. 906 Waldorf, MD 20603 19a. Informant's Name/Relationship (Type, Print) Desiree Powell/ Daughter 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

20c. Location - City or Town, State

Baltimore, MD

4-21-2012

Physician/ Medical Examiner 4 Donation 5 Other (Specify)

Signature of Funeral Service Licensee

To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending ohysician and

Division of Vital Records, P.O. Box 68760

	21. Signature of Funeral Service License	Morton	22. Name a	and Addres	ss of Facility Ja Laurens	ames A. St. B	Mor alti	ton & Somore, MD	ns F,H.,Inc. 21217
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aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):							T _E
dical Ex	resulting in death) Last	Due to (or as a consequence of):							
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic 5 Other (s		y			23d. Date of de Month	livery Day Year
ted by Pł	Part II. Other significant conditions cor	ntributing to death but not resulting in t	he underlying	g cause giv	ven in Part I.				the cause of death?
Comple							opsy formed?	prior to death?	topsy findings available completion of cause of
Be	25. Was case referred to medical examiner?	ospital:			ace of Death (Che	ck only one)			
၉	1 Li Yes 2 Linko	1 Inpatient 2 ER/Outpa	atient 3 🗌 [Othe	er: 4 Nursing I	Home 5 Res	sidence	6 Other (Spec	ify)
ficate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year) 28b. Tim inju		28c. Injury work 1 🗌		28d. Describe	how inju	ury occurred	
al Certi	4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, facto	ry, office		28f. Location City or To	(Street a own, Stat	und Number or Rui te)	ral Route Number,
Medical Certificate:	(Check 2 Medical Examine	cian: To the best of my knowledge, de- er: On the basis of examination and/or in Practitioner: To the best of my knowle	vestigation, in	n my opinio	n, death occurred	at the time, date	and place	ce, and due to the	cause(s) and manner stated.
	29b. Signature and title of certifier	u_	29	c. License	number	- 1		ate signed (Month	

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 12049 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year h 200 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death Jultinore If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birt Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) X M 2 D F Director -26-9617 Nov.30,1924 87 N.C. Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Pikesville Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a o injury or other traumatic event, the Medical Examiner must be Funeral 4107 Colby Rd. 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", If Yes, Give Year or Dates 1 Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Steel Worker Bethlehem Steel 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Annabelle Galbreth Lewis Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pikesville, Md 21208 4107 Colby Rd. Louise Lewis/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Cem April 21,2012 Baltimore,MD 4 Donation 5 Other (Specify) Woodlawn 22. Name and Address of Facilit any SCRUGGS PRESTON S В TUNERAL HOME Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physiciar by Physician/Medical P.O. Box 68760 IF FEMALE ase 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown for 5 ☐ Other (specify) Month Day Year Pregnant at time of death 4 Pregnant
9 Unknown detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 thinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 has autopsy this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital director, Be 26. Place of Death (Check only one) Hospital Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 24 hours after death.
Funeral Director: After this etely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural Accident 5 Pending work? 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar filed (Month, Day, Year)

Belica Pre A

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			Please	Type or Pri							•		-	ible.	
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116	Funeral		Social Security Number 6. 8	Sex 7. Ag		ast birthday)	If Under Months				8. Date of Bi	rth av. Year)		9. Birtho	place (State or Foreign
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0036	urs after ural", or Il Exami	Completed by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.			Yes	_						white, white, which will be with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window with the window window with the window with the window with the window with the wi	
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George Lang	permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner and once.	To Be	17. Father's Name (First, Middle, Last) George Lang								T. La			=)	
Mar	d 2 shou alth and n 27 is m er traums		19a. Informant's Name/Relationship (Catherine Lai				_				Route Number			tate, Zip 0	*
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Baltiı	permit. P Departm Importal any injur		21. Signature o Fundal Service Licer	**			. Name an	d Addres	s of Facilit	ty 30	0 MAc	e A	ve.	Balt	to. MD
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. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medic	PEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	al death 3	Ectopic p Other (sp	regnancy ecify)	4				23d. Da	te of delive	ery Day Year
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Vita	Physiciar this certif ral directo	To Be	examiner? 1 🗌 Yes 2 🖫 No	Hospital:	ent 2 🗆	ER/Outpatien	t 3 🗆 DC	Othe	r: 4 Nu		me 5 Resi	dence	6 🗆 Othe	er (Specify)
on of	nding Ph ith. : After th e funeral		27. Mannar of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of inju (Month, Day	ry	28b. Time of injury		Bc. Injury work?	at		28d. Describe				
Division of Vital Records,	l or Atter after dez Director d in by th	Certificate:	3 Suicide 6 Could not l 4 Homicide determined	De 29a Plana of Iniu			et, factory	office			28f. Location (City or Tox			er or Rural	Route Number,
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	To the within To the comp	2	29b. Signature and title of certifier	1	o bost of fi	ny knowledge,	29c.	License	number	e and pia	ce, and due to	29d. D.	ate signed	(Month, L	Day, Year)
	1		30. Name and address of person who		1D. eath (Item	23a) (Type, P	rint)	<i>y</i> 00	36 59	101		04	116	201	
	0		Benjamin Lee, MD 31. Date Miled (Month, Day, Year)	669	Re	volutio	n St	1	Hai	ure	de G	rac	ce,	MO	21078
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 16°, 2012^{xeal} 3:55 A M F. Joseph Lee Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Stella Ma</u>ris Baltimore Timonium 7. Age (In yrs. last birthday) 6. Sex Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours (Month, Day, Year) Director 219-16-3686 1 X M 2 □ F 87 Oct. 3, 1924 Maryland Usual Residence of Deceder 28a-f shov with the Maryland items 23a or 28a-f sho her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 105 Kenilworth Park Drove, 21204 U.S.A. death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, If Hygiene.
Jother than "natural", or itervent, the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Page 1 and 2 should be Ned within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. 3 Divorced 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Operations Staff Officer Railroad Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ella Kelly <u>Samuel</u> _ee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21204 19a. Informant's Name/Relationship (Type, Print) C. Lee Wife 105 Kenilworth Park Drive, #4B Towson, Marvland Anne 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dufairey eValleyer place) Memorial Gardens 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-19-2012 Timonium Maryland Service permit. 21. Signature 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road 21204 Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. erval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) use as the burial-transi Due to (or as a consequence of) attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform Hospital or Attending Physician: The 24 hours after death.
 Funeral Director: After this certificate It 2 🗌 No 1 Yes **Division of Vital** completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

State

IDV

JOSEPH

2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201

32. Rg

TRACIE MORGAN, CRNP

APR 1

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Middle, Last) 2. Date of Death 3. Time of Death 1 Decedent's Name (First 240 Physician/ 10 Medical ility Name (if not institution. aive street **Examiner** DIR D 01 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In vrs. last birthday 6. Sex **Funeral** Min. Director 216-36-3570 1 □ M 2 🕅 F 94 01/18/1918 NY Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland must be notified at Director 1 🗆 Yes 2 🛣 No BALTIMORE MD RANDALLSTOWN 10f. Zip Code 10a. Citizen of What Country? ō 10e. Street and Number 23a Funeral 4010 MCDONOGH ROAD 21133 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12 Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces? Black, White, etc. 0 Completed by 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural", 3 X Widowed 4 Divorced WHITE the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) CLERK STATE OF MARYLAND Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ FOREMAN MAYER FLITT JULIA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARILYNN GLASER / DAUGHTER 4010 MCDONOGH ROAD. RANDALLSTOWN, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date X Burial 2 Cremation 3 Removal from State 04/16/2012 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) BNAI ISRAEL CONG. SOL LEVINSON & BROS., INC. 22. Name and Address of Facility Signature of Funeral Service Licens 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Q RS. Ph__ician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underl in Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 SB IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a, Was an page 2 s has perform certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Date of injury (Month, Day, Year) 28c. Injury at Certificate: work? iniun 1 Natural 5 Pending s after death.

I Director: Aff Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29b. Signature and tit

Registrar

State

8

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#26perpHYS, G926, 4/18/2012, WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Margaret A. Miller 2012 8:00 Medical Apri 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomoico 6116 Irving Way Salisbury Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🕱 F Month, Day, Year) 7 Maryland Yrs **Director** 212-22-4392 85 Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Wicomoico Salisbury 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 600 Tressler Drive 21801 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No 2[†]215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. White 3 X Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 8 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frieda M. Bernadette John E. Biggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Miller / Son 6116 Irving Way, Salisbury, Maryland 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Bonation 5 Other (Specify) Loudon Park Cemetery 4/12/2012 Baltimore, Maryland 21. Signal of Funeral Service Lice 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner Date to for as a consequence of If any leading to in medicause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past № months?

1 ☐ Yes 2 ☒ No

9 ☐ Unknown Month Day Year signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 3 Probably 4 Unknown should I Completed No 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy prior to com death? After this certificate has funeral director, page 2 Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one Son's Hospital: Other: 4 Nursing Home ျှ 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6X Other (Specify) Home 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural Accide 5 Pending injury Accident Investigation within 24 hours after death

To the Funeral Director: A
completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 Certifying Nurse Practioner: To the bes only one 29d. Date signed (Month, Day, Year) gnature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ,Da 2012 MARY PATRICIA MAGUIRE April 15, 4:00P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6005 Hunt Ridge Road Baltimore Baltimore Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Hours 217-26-1557 **Director** 1 □ M 2**XX** F 83 01/17/1929 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County aţ 10c. City, Town or Location Director 10d. Inside City Limits notified 1 Yes XXXVo Maryland Baltimore Baltimore 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 6005 Hunt Ridge Road #3411 21210 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify: Completed 3XX Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) n and Mental Hygien 7 is marked other tl Homemaker Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Motor Thomas Joseph 18. Mother's Name (First, Middle, Maiden Surname) Louise Sherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mairi Pat Maguire DTR 730 East Lake AVenue Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 ☐ Burial 2 XX remation 3 ☐ Removal from State GreenMount Crematory | 04/18/2012 | Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) ignature of Fund Vervice Lice 22. Name and Address of FacMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastat Ph. sician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Due to (or do a consequence on) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year signed by the at the detached for Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 No 2 Accident Investigation Could not be Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. ETTINGER SIGNEY KIMME

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Mortth, Day, Year)

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ Louise B. Meadows 9, 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Harford Bel Air 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🔀 F Months Days Hours NOV . IS , West Virginia 1931 **Director** 236-48-7926 80 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at Director Harford Maryland Abingdon 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 21009 USA 1403 Emily Court East . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Administrative Supervisor Be 001 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lucille John William Chester Bradford (nmn) Yearout 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1403 Emily Court East, Abingdon, MD 21009 Tom Meadows / Son Baltimore, 61161h 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4-12-2012 Beckley, West Virginia Blue Ridge Mem. Gdn 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature if Fune is Servi 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final Physician/ INTRACERUBRAL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Bradford Examir Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) led by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 1001156 Month 5 Other (specify) Pregnant at time of death Unknown signed by t d be detach Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen medaws 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) 20056296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper chesapeake Drive. Bel Air, MD. 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20

Certificate of Death

12055

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Opset and Death

Day

White

1 🗆 Yes 2 🕇 No

1:04 P M

State Registrar

)0.50n

12-02959 Amy Mickel Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 12056 State of Maryland / Department of Health and Mental Hygiene

1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Amy Mickel Month Day April 15, 2012 2103 hrs **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death N/A 3957 Cloverhill Street 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign California 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 217-64-1502 1 M 2 F 56 May 20, 1955 Country) Usual Residence of Decedent 10a. State 10b. County IOc. City, Town or Location 10d. Inside City Limits 1 Yes 2 No N/A Maryland Baltimore , or items 23a or 28a-f shorr must be notified at once. Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 71 is marked other than "natural", or items 23a or 23a-f she
isjury or other transatic event, the Medical Examiner must be notified at once. 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3957 Cloverhill Road 21218 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian, Black Armed Forces? White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 X No specify: Specify: Asian 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Compl 3 Dog Walker Self Employed 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) 8 Howard Mickel Frances Griffin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Evan Mickel, Brother 4 Broodridge Lane Lutherville, Maryland 21093 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Date crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. 04/17/12 Baltimore, Maryland 4 Donation 5 Other Specify ²² Name and Address of Facility Cremation Society Of Maryland, 299 Frederick Road Baltimore, 21. Signature of Funeral Service Licensee Thomas Gregor Inc. Maryland 21228 roma art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending pbysician and led for use as the burial - transit Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Dav Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atter I be detached for u 1 Yes 2 ✓ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 ✔ No 3 Probably 4 Unknown Kidney disease, DM Completed funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? Yes 2 V No 2 No 25, Was case referred to medical 26.Place of Death (Check only one) 8 Hospital: 1 Other₄ DOA Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 1 Yes 27 Manner of Death 28a. Date of Injury (Month, Day, Yeer) 28b. Time of Injury 28c. Injury at Work? 28d, Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No 5 Pending death. the Director: 2 Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 24 hours after 3 Could not be Suicide or Town, State) within 24 hours a 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. April 16, 2012 ELO. alp 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 APR 1 8 2012 32. Registrar's lignatur State

Registrar

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				Cen	tificate of L	Death			12057
	Physicia Medi	cal	1. Decedent's Name (First, Middle, Last) Eugene G. Manner				2. Date of Dea Month April	th Day Year 17 2012	3. Time of Death 7:30a M
	Examir	ner	4a. Facility Name (if not institution, give street and number) 703 Pleasant Hills Road		Kings	r Location of Death	- 71	4c. County of Dea	
	Funeral Director		5. Social Security Number 219-22-5711 6. Sex 1 📈 M 2 🗆 F 83		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Nov- 1928 9. Bi Year) 1928 C	rthplace (State or Foreign ountry) MD
	aryland a-f show fied at	ector	Usual Residence of Decedent 10a. State	y, Town or Loca Mid	ation Riv				10d. Inside City Limits
	vith the Mi 23a or 28 st be noti	Funeral Director	10e. Street and Number 3539 Buckboard Lane		10f. Zip Code	21220		10g. Citizen of What C	1 Yes 2 XNo ountry?
9200	1 and 2 should be filed within 72 hours after death with the Manyland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates.	lf .	/as Decedent of H Yes, specify Cuba ☐ Yes 2 🖺 No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whit	
21215-0036	in 72 hou e. han "nati Medica	amplet	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give ki	ent's Usual Occup ind of work done of NOT use retired)	ation during most of worki	ng	16b. Kind of Business	Industry
121	d with tygien ther th	Be C	9th	Fir	eman				more City
Maryland	uld be file 1 Mental H marked o natic eve	To E	17. Father's Name (First, Middle, Last) George Manner			18. Mother's Name Thel	(First, Middle, M ma Sou	,	
e, Mai	nd 2 sho lealth and m 27 is r her traun		19a. Informant's Name/Relationship (Type, Print) Joseph Pupa /son					City or Town, State, Zindsor MD	
Baltimore,	permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other tr once,		20a. Method of Disposition 1	ace of Dispos emetery, crema ayvier	sition (Name of atory or other plac W Crema	tory 4/2	20/12	20c. Location - City of Baltimo	
Ball	permit. Page Department of Important: If any injury or once,		21. Sign vory of Funeral Service Licensee	22.	Name and Addres	ss of Facility 3 (00 Mace	Ave. Ba	lto. MD ex 21221
- _P	hysician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	DCE	r the mode of dyin	g, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
A.	Examiner	er	Sequentially list conditions, if any, leading to immediate b.						
6	be executed sician and burial-transit	Examiner	Cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence)					1	
09289	cate be exe physician the burial	ca	d	31100 017.					
). Box 68	To the tooping or Arendring Prysician: The law requires that the death certificate within 24 hours after death. To the Funeral Brector After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	Ideath 3 🔲	Ectopic pregnand Other (specify)	у		23d. Date of de Month	elivery Day Year
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Vita	ysicie iis cert direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 E	ER/Outpatient	Othe	er: 4 Nursing Ho		ence 6 Other (Spec	city) Brother's
on of	ath. r: After the re funeral	Certificate:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28b. Time of injury	28c. Injury work	at		w injury occurred	7,02110
Division of Vital Records,	ar or Arress after de la Directo	l Certif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)		et, factory, office	:	28f. Location (Sti City or Town	reet and Number or Ru , State)	ıral Route Number,
)	n 24 hour n 24 hour ne Funera pleted filk	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practioner: To the best of my	and/or investig	gation, in my opinic	n, death occurred at	the time date an	d place and due to the	calleg(e) and manner stated
	withi To #		29b. Signature and title of certifier		29c. License	number	2	9d. Date signed (Mont	h, Day, Year)
_	Q		30. Name and address of person who completed cause of death (Item 2) BAYNOUNG, M. D. 80 31. Date fined (Month, Day, Year) 32. Registrar's 2, nature of the strar's 2, na	23a) (Type, Pri	BELA1	R RA	BAL	TO. MN	21236
	Stat	te	31. Date filed (Month, Day, Year) 32. Redistrar's Junqu	K.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Anna M. Murphy April 2012 4:09p M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death ac. County of Death
Anne Arundle 96 Mary Lane Glen Burnie 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** sept10,1932 1 □ M 2 🔀 F 214-30-4177 **Director** 79 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location be notified at Director 10d. Inside City Limits MD Anne Arundle Glen Bernie 1 Yes 2X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 96 Mary Lane 21061 USA and 2 should be filed within 72 hours after death Health and Mental Hygiene. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc by 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Completed 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meones. Elementary/Seconday (0-12) College (1-4 or 5+) Trucking Industry Billing 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Paulus Johanna Mortiz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Murphy /son 96 Mary Lane Glen Bernie MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Buria 2X Cremation 3 ☐ Removal from State Bayview Crematory 4/17/12 Baltimore MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death CHRONIC Physician/ OBSTRUCTIVE disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, rany, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on the burial-tran that initiated events Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 for use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Dav Year signed by the a 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting he the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MBETES MECLITUS Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CORUNARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? erebru utcultel A Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗌 No Accident
Suicide within 24 hours after death To the Funeral Director: Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

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eath (Item 23a) (Type, Print)

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30. Name and address of person who completed cause of

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 6 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFOR HAURO ARFORD MOMORIE 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 1 XM 2 □ F Hours 0573747927 Virginia Director 84 229-26-0146 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Havre de Grace 1 X Yes 2 □ No 10f. Zip Code 10e. Street and Number United States of Completed by Funeral 21078 301 Fountain Street America 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 X Yes 2 ☐
If Yes, Give Black, White, etc 1 Never Married 2 Married 2 No 21215-0036 White 1 Tes 2 No Specify: Specify: 3 - Widowed 4 Divorced Year or Dates. WWII 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Painting Painter Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Virginia Haga |Claiborne McCarter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21078 301 Fountain St. Havre de Grace, Maryland 19a. Informant's Name/Relationship (Type, Print) Dennis McCarter (son) Angel Hill Cemetery 04/20/20 12 Havre de Grace, 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Maryland 21. Signature of June al Sc 22. Name and Address of Facility Zellman Funeral Home, P.A. S. Washington St. Havre de Grace, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ASTRO. disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant Box 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 1 Yes 2 9 Unknown Yes 2 No detached P.O. us certificate has been signed by director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No **Division of Vital** Be Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 욘 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA After this To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral o 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 \square Pending work? 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner To the best of hydrocyledge, death unaimed at the flave date and place, and due to the naimfall and manner as stater 29b. Signature and title of certifier 29c. License number 5+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 Sallie Province Mink April 6:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Keswick 8. Date of Birth
Feb. 17, 1947 9. Birthplace (State or Foreign Country)
Indiana 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. ial Security Number **Funeral** Days Hours 304-50-4363
Usual Residence of Decede 1 □ M 2 🗓 F **Director** 65 28a-f show 10d. Inside City Limits 10b. County with the Maryland ms 23a or 28a-f shor must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 No Baltimore Lutherville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 USA 15 Elphin Court #101 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 [XNo Specify: "natural" 3 Widowed 4 XDivorced white Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than College (1-4 or 5+) **5+** Elementary/Secondary (0-12) Medical Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Jean B. Smith William D. Province and l 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health a 250 W. Pratt Street Suite 1700; Baltimore, MD 21201 Thomas Mink son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If its
any injury or ot 1 Burial 2XA Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 4/17/2012 Towson, MD 1050 York Road 22. Name and Address of Facility 21. Signature of Fig. Towson, MD 21204 Inc. kuck Towson Funeral Home, ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or com shock, or heart failure. List only e cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Unknow alioblastoma Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence on. Cause (Disease or injury that initiated events resulting in death) Last ng physician and as the burial-trar Due to (or as a consequence of): ed by the attending physician detached for use as the buris Physician/Medical ospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) g Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 24 hours after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled i Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and titl 29d. Date signed (Month, Day, Year, D0054056 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20V 5+ Salvia 404 BZIT a

State

Registrar

31. Date filed (Ma

APR 1 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 For State Registrar 12061 Date of Death Day Physician/ Month 1:19 A M zaheth Medical or Location of Death 4c. County of Death **Examiner** Baltimore 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** Director 1 M 2 W 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Himore 1 Ves 2 No 10e. Street and Numbe 10g. Citizen of What Country? USA Completed by Funeral aiaa3 lonroe Was Decedent Ever Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 If Yes, Give 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☑ Divorced ack Year or Dates 16a. Decedent's Usual Occupation
(Gwe kind of work done during most of working if e DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary (0-12) College (1-4 or 5+) tssembler Be 8. Mother's Name (First, Middle, Maiden Father's Name (First, Middle, Last) မ N. Monroe 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tonce. 20b. Place of Disposition (Name of cemetery, cremator) or other p 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Atherosclerotic CESGRASTY Vasculer disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical requires that the death certificate be the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown jo Month Day Year 9 Unknown detached by been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy perform Hospital or Attending Physician; The After this certificate Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No ္ဝ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 11, 2015 D50583 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 V 13ACTIVIONE A En MANY CAND 0-5 erm State

DHMH 17 Rev 06-2011

Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar		State of M	laryland		irtment tificate			d Mental H	ygiene Reg. No	ZUI	2	12062
	Physicia Medic		1. Decedent's Name	e (First, Middle, Las M A	PRIC	E					2. Date of D	eath D	1 201	>	3. Time of Death
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	Funeral		Atrium 5. Social Security N	Village A	Assisted I	ge (In yrs. Ia:	st birthday)	If Under 1		Mills If Under 24 I Hours N	Hrs. 8. Date of B	irth	9. E		ce (State or Foreign
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	91		30. Name and add	ress of person who	1 /1	death (Item	23a) (Type, F	Print)	1	11	1 11	n	7	 	1061
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	Registra		HLU T	D CAIL YO	Marine No.	17									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Dorothy Elizabeth Posluszny Physician/ $0^{MONT}_{4}/13/20^{Day}_{0}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Harford Memorial Hospital Havre de Grace If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year Social Security Number Funeral West Virginia Days Hours 11/02/1923 88 Director 215-20-7392 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10a, State Director Maryland Harford 1 Tes 2 X No Belcamp 10g. Citizen of What Country?
United States of 10e. Street and Number 10f. Zip Code Funeral 1123 Belcamp Garth 21017 America

14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Family 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sally Elizabeth Haines Henry Washington Malone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kathy Jo Lawrence (daughter) 408 Heather Way, Havre de Grace, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 04/21te/2012 1 🔏 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) etery, crematory or other place) Middle River, Holly Hill Cemetery 22. Name and Address of Facility Zellman Funeral Home, P.A. 21. Signature of Furters S. Washington St. Havre de Grace, 23a. Part 1. Enter the decase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ostcomy elite Physician/ disease or condition Medical resulting in death) Examiner (on nishre Sequentially list conditions, Examine if any, bearing to in recitate cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 menths?

1 Yes 2 No
9 Unknown Pregnant at time of death ed by the a Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. within 24 hours after death.

To the Funeral Director: After this certificate has been signed to completed filled in by the funeral director, page 2 should be det Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 Yes 2 No Yes 2 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner?

1 Yes 2 No Dorohy Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State

Registrar

(Check

29b. Signature and title of certifier

Lvonne 31. Date filed (Month, Day, Year) APR 1 8 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mn

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

00064615

29d, Date signed (Month, Dav. Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. = State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death April 16 Day 2012 Year Physician/ Irene G. Philipp 12:17 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 245-24-4964 89 Director 1 🗆 M 2 🕱 F Aug. 16 1922 North Carolina Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits **Funeral Director** notified Maryland Baltimore Towson 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r 800 Southerly Road Apt. 629 21286 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ★ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, of Health and Mental Hygiene. item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify. Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager Metal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Gahagan Creasy Gosnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Warren Philipp / Son 2113 Forest Ridge Road, Timonium, Maryland 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HilltopServiceCorp. 4/17/2012 Towson, Maryland Signature of Funeral Samuel Censes 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ 14 disease or condition Medical resulting in death) Examiner 2012 Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 16, attending physician and the burial-tra use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death signed by the at id be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? PHILIPP24a. Was an has performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes 2 No Yes 2 📉 filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ျှ 1 Yes 2 X No IRENE 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner. On the basis of occurring the past of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) nelia 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD JUNECIA WHITE, CRNP TIMONIUM, MD 21093

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

12065 State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 13,2012 Physician/ 6:20p M Andrew Thomas Rainey III Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 7614 Spruce Road Dunda1k If Under 1 Year Months Days . Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Hours March 17, 1953 Maryland 218-62-4879 59 **Director** 1 🛛 M 2 🗆 F Yrs. Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 X No MD Baltimore Dundalk 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō permit. Page 1 and 2 should be filed within 72 hours after death with th Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a on any injury or other traumatic event, the Medical Examiner must be a once. Funeral 21222 USA 7614 Spruce Road Was Deceden ... Armed Forces? 1970 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in L 14. Race - American Indian, 11. Marital Status 1970 1 X Never Married 2 - Married þ Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance Self Employed Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last 2 Dorothy Wyland Thomas Andrew Rainey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7614 Spruce Road Dundalk, Maryland 21222 Cynthia K. Feit / sister 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 04/16/2012 20a. Method of Disposition 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State |Baltimore,Maryland 4 Donation 5 Other (Specify) Custer 22. Name and Address of Facilit Cremation Society of Maryland, Inc. Signature of Funeral Service Licensee Stephanie 0 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition BOAL Medical resulting in death) Due to (or as an insequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signer should be c 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated npletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2.

To the F
complet only one d title of certifie 29b. Signature a 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10V 6701 N CHARLES PR 1 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar	State	of Maryla		artment of F tificate of D		Mental Hy	giene Reg. No. 20	12	12066
	Physicia	n/	Decedent's Name (First, Middle	le, <i>Last)</i> Rob <i>e</i>	rt	Henry	Rit	tie	2. Date of Dea Month April	ath Day Y	/ear	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution			пенту		Location of Death		15 201		7:05 A M
	ZAGITIII		Genesis Herit	tage Nursi	ing Hor	ne		ında1k		,		more Co.
	Funeral Director		5. Social Security Number 111-03-7544	6. Sex 1X M 2 □ F	7. Age (<i>ln yı</i>	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day April	h /, Year) 30,1916	9. Birthp Coun New	place (State or Foreign try) York
	ld now	ڀ	Usual Residence of Decedent 10a. State 10b. County	,	100	City, Town or Lo	cation				-	0d. Inside City Limits
	larylar sa-f st ified	Director		Baltimore	1.55	ony, 101111 di 20		Dund	la1k		- 1	1 ☐ Yes 2 🛣 No
	the M	I Dir	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	at Cour	ntry?
	h with	Funeral	2611 Lynbrook				212	222		United	Sta	tes
_	s filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.		11. Marital Status1 ☐ Never Married 2 ☐ Married	12. Was Dece			Nas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black,	Americ White, e	
9500-612	rsafte ral", c Exam	ed by	3 ₺ Widowed 4 □ Divorced	If You Cit	ve.	wii	☐ Yes 2X No	Specify:		Specify:	V_{\cdot}	hite
ည် က	2 hour	plet		ent's Education est grade completed)		lent's Usual Occupa		ang	16b. Kind of Busi	ness Inc	dustry
17.17	thin 7 ene. • than he Me	Completed	Elementary/Seconday (0-12) 12 Years	College (1	-4 or 5+)	life. D	O NOT use retired) Metal Me		3	Fodove	.1 0	overnment
ō	be filed w ental Hygi rked other ic event, t	Be	17. Father's Name (First, Middle,	Last)		Taneer	metai ne		ne (First, Middle,	Maiden Sumame)	IT G	overnment
yiar	should be file and Mental I is marked or raumatic eve	2	Frank Rittie					J	eanette	Gilbert		
, Maryland	permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev		19a. Informant's Name/Relations Mr. Robert F.		Son)					; City or Town, Stat stertown ;		
baltimore,	e 1 an t of He If item or oth	Н	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation	3 ☐ Removal from	State		natory or other plac	e)	Date	20c. Location - C	ity or To	wn, State
	it. Pag rtmeni rtant: njury e		4 Donation 5 Other	Specify)	Ga		f Faith (Maryland
g	perm Depa Impo any i		21. Signature of Funeral Servi	LV/es	_	D	Name and Address uda-Ruck 922 Wise	Funeral - Ave. Du	Home of ndalk,	Dundalk, Maryland	Inc 21	222
			23a. Part 1. Enter the disease, o shock, or heart failure. List	r complications that only one cause on ea	caused the d ach line.	eath. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Ph_sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to	(or as cons	equence of:	+1 [N9	moth	M		+	Onset and Death
	Examiner	L	Sequentially list conditions,	C	SCON	200	Arter	J N	ROPEZ	و		
в	red nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to	(ur as a suns	tensi	•	7				
,-	cate be executed physician and s the burial-transit	al Exa	that initiated events resulting in death) Last	c. Due to	(ol as a cons	equence of):						
9	cate b	edical		d							\pm	
9	ending use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pre	gnancy Fetal death 3	Ectopic pregnanc	v		23d. Date	of delive	ery
. Box	re death / the atte ched for	Physician/M	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		nant at time		Other (specify)	y		Month	1	Day Year
Σ	es that the ingred by be detailed	ρ	Part II. Other significant conditi	ons contributing to c	leath but not	resulting in the u	nderlying cause giv	en in Part I.		bacco use contribu		
ecords,	require	eted							24a. Was a			pably 4 Unknown
Lecc	The law ate has l page 2 s	Completed							autop perfo	sy prio megi? dea	or to cor ath?	mpletion of cause of
NE A	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			26. Pla	ace of Death (Chec				
0	r this or	e: 10	1 Yes 2 No 27. Manner of Death	1	of injury	ER/Outpatier 28b. Time of	t 3 DOA 28c. Injury	4 Nursing Ho		ence 6 Other (Specify)	
	arth. r: Afte	icat		igation	th, Day, Year,	injury	work'	? Yes 2 □ No	200. 2000	ow injury occurred		
DIVISION	Il or Atter after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	ningd 28e. Place	e of Injury - At ing, etc. (Spe		eet, factory, office		28f. Location (S City or Tow	treet and Number on, State)	or Rural	Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medical I	g Physician: To the base	sis of examina	ation and/or invest	igation, in my opinio	n, death occurred a	t the time, date a	nd place, and due to	the cau	use(s) and manner stated.
	To the within To the compl		only one) 3 L Certifying 29b. Signature and the of certifie	9 Nurse Practioner:	to the best o	r my knowledge, c	29c. License			29d. Date signed (A	_	
			1/0	<u> </u>		D		D234	62	4/16	115	
	D1,			who completed caus	·	tem 23a) (Type, P	coinds	12.d	Ct. F	allston	1.	FPOIS DN
	Stat		31. Date filed (Month, Day, Year)	32. F			CONTON	and .	7	WIND W		-10001
	Registra	ır	AFR I	8 2012 1	men	B. A	acres					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joan D. Silber April 13,2012 6:03pMedical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore . Social Security Numbe If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Oct. 28, 1931 **Funeral** Birthplace (State or Foreign Country) Hours Director 213-30-4415 80 1 □ M 2**X** F Mary land Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City. Town or Location 10d. Inside City Limits Director Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 212 Aigburth Road, unit 215 21286 USA 11. Marital Status 12. Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: 3 Widowed 4 X Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Librarian Baltimore County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) |John Earl Fendall Madeline Mae Schwartz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jamie Frank / daughter 2024 Geist Ave.Reisterstown,Maryland 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State Metro Crematory, The. 0416/0212 Baltimore,Maryland 4 Donation 5 Other (Specify) eral Service Licensee Stephnaie 22. Name and Address of Facility Cremation Society of Maryland, inc Custer 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician/ disease or condition Due to (or as a consequence if): Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of): that initiated events burial-tra resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as th IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? for Pregnant at time of death 5 Other (specify) Month Day Year ed by the a 1 L Yes 2 b 9 D Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ thknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? death? 2 NO 1 🗌 Yes 2 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No မ Hospi a 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Naturai 5 \square Pending work 2 No Accident Investigation filled in by the 24 hours after deat Funeral Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the I Certifying Nurse Practitioners To the Seat of my Incomed only one 29b. Signature and the of certifie 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

6V

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

01

NCHARLES

KUMAR

31. Date filed (Month, Day, Year)

D71040

SULTIB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 12068 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dale H. Sample <u> April</u> 2012 6:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 74 217-36-3899 1938 Balt. Maryland **Director** Feb. Usual Residence of Decedent shov or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Baldwin Harford Maryland 1 Yes 2 No 10f. Zip Code 21013 10e. Street and Number 10g. Citizen of What Country? United States permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. Funeral 2515 Greene Road of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 K Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: white Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County Firefighter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Bessie Ball Hyland Sample 19a. Informant's Name/Relationship (Type, Print)
Mrs. Shirley L. Sample/wife 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Gode) 2515 Greene Road Baldwin, Maryland 21013 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ApriDate 18, Evans Funeral 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 <u>Bel Air</u> 21. Signature of Wheral Servi License Peaceful Alternatives Funeral and Cremetion Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ b/e Droba disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): 96162 Sample Dale 1-11/191 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) I or Attending Program...

safter death.

I Director. After this certificate has been signed by the attered in by the funeral director, page 2 should be detached for it. in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 🗌 Yes Yes 2 7 To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier з 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and the of pertifier 10057 10+ Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper Chesapeake Dr., Bel Aie, MD 2104 BarrueTu M erman 31. Date filed (Month, Dav. Year) State

DHMH 17 Rev 7/2009

Registrar

12-02907
Brandon Simms

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 12069 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ April 15, 2012 Medical Examiner 0142 hrs Brandon Simms 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death University Hospital **Baltimore** NA 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY **Funeral** oreign Months Days Hours Director 215-23-5734 23 10-25-88 Country) 1XXM 2 F MD Yrs Usual Residence of Decedent 10a, State 10d. Inside City Limits 10b. County 10c. City. Town or Location 1X Yes 2 No or items 23a or 28a-f show mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiene.
portant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at once. MD NA Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1306 McCulloh Street 21217 USA Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No White, etc. African Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 2 X No Yes, Give Year 1 Yes 2 No specify: Specify: American Widowed Divorced <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) University of Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Floor Technician 12th Grade NA Maryland 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Brian Simms Patricia Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Collins-Mother 1306 McCulloh Street Baltimore, Maryland 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Itimore, crematory or other place King Mem. Pk. 1 X Burial 2 Cremation 3 Removal from State 04-18-12 Randallstown, MD Donation 5 Other Specify. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician each line failure. List only one cause Between Onset and Maded Death a, Multiple Gunshot Wounds Immediate Cause (Final diset Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical $\mathbf{x}_{\mathsf{AMENDED}}$ #2, per me, g927 5-30-12 sm has been signed by the attending physician at should be detached for use as the burial -UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ Certification: To Be Completed ailable e of this certificate After

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

					1 Tes	2 V NO 3 Probably	4 Unki
					24a. Was a autop perfor	sy prior to comp med? death?	
25. Was case referred to medical	-	•		of Death (Check	only one)		
examiner? 1 ✓ Yes 2 No	pital: 1 🗸 Inpatient 2	ER/Outpatient 3	DOA	Other Nursin	ng Home 5	Residence 6 Other:	
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year) Apr 13, 2012	28b. Time of Injury 2020 hrs	1	y at Work? ∕es 2 ✔ No	28d. Describe h Subject shot	now injury occurred	
3 Suicide 6 Could not be determined	28e. Place of Injury - At ho (Specify) courtyard	ome, farm, street, facto	ory, office b	•	or Town, S	Street and Number or Rural R tate) y Court, Baltimore, MD	oute Number
one) 2 Medical Examiner: Or	To the best of my knowledges the basis of examination and manner stateds	•				e(s) and manner as stated and place, and due to the cau	use(s)
29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Month, L	Эау, Year)
alle	12		O.C.	M.E.		April 14, 2012	
30. Name and address of person who com	pleted cause of death (Item	23a)					

900 W. Baltimore Street, Baltimore, MD 21223

Medical

State

Registrar

Zabiullah Ali, M.D.

31. Date filed (Month, Day

APR 1 8 2012

Assistant Medical Examiner

32. Registrar's Signature

City

			Please	Type or Pri							_		
			1 - State of Maryland / Department of Health and Certificate of Death						d Mental H	ygiene Beg No	2012	12070	
	Physicia Medic		Decedent's Name (First, Middle, Lass Bennie Ledi	,				2. Date of D Month	Date of Death Month Day Year				
	Examir Funeral Director		241-48-4379	OF BAL	TIMORE (In yrs. last birth	nday) If Un	4b. City, Town, or Location of Death 3 ACTIMORE () If Under 1 Year If Under 24 Hrs. 8, Date of				4c. County of Death N/A Birth Day, Year) -1935 4c. County of Death O Birthplace (State or Foreign Country) NC		
Baltimore, Maryland 21215-0036	aryland a-f show fied at	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town MD Baltimore Balti									10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	with the M 23a or 28 ust be noti	Funeral Director	10e. Street and Number 4800 Seton Drive			10f. Zip Code 21215				-	10g. Citizen of What Country?		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy rigury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Yes 2 □ No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 No Specify:				- 1	14. Race - American Indian, Black, White, etc. Specify: Black		
	vithin 72 hou liene. r than "nati	Be Completed by	(Specify only highest grade completed) (Give Elementary/Seconday (0-12) College (1-4 or 5+)				edent's Usual Occupation e kind of work done during most of working DO NOT use retired) INSPORTATION				16b. Kind of Business Industry Self Employed		
	d be filed w Mental Hygi arked othe itic event,	To Be	17. Father's Name (First, Middle, Last) 18. Mothe					18. Mother's	Name (First, Middle, Maiden Surname) da Brown				
	and 2 shoul fealth and I em 27 is ma her trauma			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katrina S. Clayton-Daughter 3517 Alameda Cir. Baltimore, MD 21218									
	it. Page 1 a intment of h intant: If ite njury or ot		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗀 Donation 5 🗀 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Millican Cemetery 4/21/2012 Whiteville, NC								e, NC		
g	Depart Department Impo		21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or comp	+/	the death. Do no	Ave.	Balt	cimore	, Maryl	and		1 E. North	
-	Physician Medical Examiner		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	a. SEPS19				g, 00011 ao 0a1a	ao or roopilatory o			Approximate Interval Between Onset and Death	
)	ysician and e burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):										
	ne death certificate y the attending phy ched for use as th	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No g Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) g Unknown							23d. Date of delivery Month Day Year			
	uires that tl n signed by ald be deta			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. END STAGE LENAL DISEASE DIABETES MELLITUS						23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown			
Records,	The law rec cate has bee page 2 sho	Completed by	HYPERTENSION					- auto	24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No				
VISION OF VITAL	within a hopping of steading frighted in the law requires that the beam betineated be within a father death. To the Funeral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	To Be	25. Was case referred to medical examiner? 1						Home 5 ☐ Residence 6 🗹 Other (Specify) HOSPICE				
		Certificate:	1 Matural 5 Pending (Month, Day, Year) injury work? 2 Accident Investigation 3 Suicide 6 Could not be						28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,				
2		Medical Cer	building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place						and due to the cause(s) and manner as stated				
			(Check 2 Medical Examiner: On the basis of examination and/or investig only one) 3 Certifying Nurse Practioner: To the best of my knowledge, de 29b. Signature and title of certifier				gation, in my opinion, death occurred at the time, date eath occurred at the time, date and place, and due to 29c. License number				e and place, and due to the cause(s) and manner stated. the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)		
	2		30. Name and address of person who co					5-000			R(L) 12	1015	
	Stat Registra		31. Date filed (Month, Day, Year) APR 1 8 2012	32. Registrar	spignature—	nal H	OSTPI	TAL OF	BALTI	MOR	· · · · · · · · · · · · · · · · · · ·		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 11 State of Manyland / Department of Health and Mental Hygiene 20 | 2 12071 For A State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month Physician/ Madeline Sisson Anril 2012 Yvonne Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Emily Drive Edgewood 8. Date of Birth 9. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 05-20-1940 Country) Months Days 1 M 2 F 71 Maryland **Director** 214-38-0580 Usual Residence of Decedent Fshow 10d. Inside City Limits 10c. City, Town or Location 10a. State event, the Medical Examiner must be notified at Director 1 Yes 2 XNo or 28a-f Maryland Harford Edgewood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral "natural", or items 23a Drive 21040 LISA 1844 Emily death Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. ◆ Rever Married 2 Married \$ Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify Specify. White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) i. Page 1 and 2 should be filed tment of Health and Mental Hy tant: If item 27 is marked out jury or other traumatic even Sigai Catherine Hock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Wayne C. Sisson, Sr. - Husband 1844 Emily Drive Edgewood, Maryland 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🙀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗋 Dopathpn 5 🗆 Other (Specify) Department of Important: If any injury or Moreland Memorial Park 04-16-2012 Baltimore, Maryland 21. Signal re of Funeral Se lice Litensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Fine Pnysician/ disease or condition resulting in death) Medical gear ditis Mechanic Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) signed by the attending physician and detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed to home settle death certificate be executed. that initiated events Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of certificate has page 2 performed 1 ☐ Yes 2 ☐ No Yes 2 No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 🗔 No 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in by determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

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State

trar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROSERT ISHAK 520 UPAR CLE

31. Date filed (Month, Day, Year)

DOOLP235

CHESOROAKE DR Ste 308 DELAIR

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 2

F E		State of Maryland / De State Registrar	epartment of Health and Nertificate of Death	Mental Hygiene 2012 12072							
Dhysia	ion/	1. Decedent's Name (First, Middle, Last)		2. Date of Death 3. Time of Death							
Physic Med	ian/ dical	Charles Franklin Shindledecker		April 10°, 2012° 11:55 A.M							
Exam	iner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death							
		6 E. Water St. Apt. 2A 5. Social Security Number 6. Sex 7. Age (in vrs. last birthda	Smithsburg	Washington							
Funera Directo	_	5. Social Security Number 204-28-0650	Months Days Hours Min	8. Date of Birth 9. Birthplace (State or Foreign Country)							
	4	Usual Residence of Decedent		Feb. 12,1935 Pennsylvania							
land sho	ţ	10a. State 10b. County 10c. City, Town or		10d. Inside City Limits							
Mary 28a-	ire	Maryland Washington	Smithsburg	1Ã Yes 2 ☐ No							
th the	Funeral Director	10e. Street and Number	10f. Zip Code 21783	10g. Citizen of What Country? $U \cdot S \cdot A \cdot$							
th with ms 2.	Iner	6 E. Water St. Apt 2A									
or ite	by Fu	1 Never Married 2 Married 1935-	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.							
s afte			1 ☐ Yes 2X No Specify:	Specify: White							
2-0050 2 hours after "natural", o	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G(cedent's Usual Occupation	. 16b. Kind of Business Industry							
han se Me	l mo	Elementary/Seconday (0-12) College (1-4 or 5+)	ve kind of work done during most of work DO NOT use retired)								
d with dygier ther t	Be C	10	pping & Receiving	Glass Company							
yiaild ild be filed Mental Hy narked oth	일	17. Father's Name (First, Middle, Last) William Henry Shindledecker		Name (First, Middle, Maiden Surname) che Stottlemyer							
II yili	ı.										
Datumore, Interpretable 21213-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any mans.		==-/		al Route Number, City or Town, State, Zip Code) 21783 P.O. Box 213 Smithsburg, MD							
1 and 1 and 1 thea item		20a. Method of Disposition 20b. Place of Dis									
Dallillor Dermit. Page 1 Department of important: If it any injury or controls.				Date 20c. Location - City or Town, State Smithsburg, Maryland							
Daliti Permit. I Departir Importa any inju		21. Signature of Funeral Service Licensee MO 14 14	22. Name and Address of Facility	J.L. Davis Funeral Home							
0 825 8 8	5	Jehre Lavis	12525 Bradbury Ave	e. Smithsburg, Maryland 21783							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of):											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): d.									
ne death certifica	Physician/Medical		as decedent pregnant the past 12 months? Yes 2 No 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)								
uires that t n signed b	þ	Part II. Other significant conditions contributing to death but not resulting in th	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 \(\text{No} \) 3 \(\text{Probably} \) 4 \(\text{Unknown} \)								
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The la	No.			performed? death? 1 \(\text{Yes} \) 2 \(\text{Maso} \)							
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e Hospital	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
To the within To the comp	2	29b. Signature and title of certifier	29d. Date signed (Month, Day, Year)								
		1/3/6	D 3847/	4/11/12							
-1		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	my ms							
TV		229 11 Jufferson Blun	5hithish	ry ms							
St Regist	ate	31, Date filed (Month, Pay, Year) 32. registrar' Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ . Day 2012 April Ethel Mae Schmelz 15 4:00 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6518 Sherwood Road Baltimore Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Hours Director 218-18-7447 88 1 M 2 X F 10/7/1923 Maryland Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6518 Sherwood Road 21239 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 XNo Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Should be filed with and Mental Hygien 7 is marked other th Customer Service Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Pleasant Rulette Seitz Ethel Virginia Callanhan traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Stephen Schmelz / Son 6518 Sherwood Road Baltimore. Maryland 21239 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Parkwood Cemetery 4/21/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician EMEN DIY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that the death certificate be executed and -trar that initiated events resulting in death) Last Due to (or as a consequence of) burial Physician/Medical Division of Vital Records, P.O. Box 68760 the nding pl IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year g Unknown g 🗌 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PIABETE MEILING 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown CORD WARY ARTERY 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hospital or Attending Physician: The law page 2 s this certificate has autopsy performed?

Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No ☐ Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00047625

DHMH 17 Rev 06-2011

State Registrar 30. Name and address of

31. Date filed (Month, Day, Year)

7600 often prive, Suite 311. Mouson, M.D. 21204

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend State of Maryland Department of Health and Mental Hygiene 2012 12074 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Medical Examiner 0400 hrs April 12, 2012 Smith Margie 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Mercy Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min Director 218-18-3415 03-28-1925 1 M 2XXF Country) USA Yrs Usual Residence of Decedent 10a, State 10d. Inside City Limits 10b. County 10c. City, Town or Location s 23a nr 28a-f show : 1 X Yes 2 No MD Baltimore permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natural", ar items 23a nr 28a-f she injury or ather traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 1020 E. 33rd ST. Apt 413 10a. Citizen of What Country? 10f. Zip Code Stadium Place 21218 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14, Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2XX No Yes 3 X Widowed 4 Divorced f Yes, Give Yeer 1 Yes 2 X No specify: Specify: Black ≦ 16a. Decedent's Usual Occupetion (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 10 Linen Purveyor Hospital 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Naomi Thompson Robert Burgess ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4010 Derby Manor, Baltimore, MD 21215 Sharon Green /Cousin 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Itimore, 1 Burial 2 Cremation 3 Removal from State crematory or other place) 04/19/2012 Baltimore, MD Measdowridge Mem Pk 4 Donation 5 Other Specify 22. Name and Address of Facility James A. Morton & Sons F.H., Inc. 21. Signature of Funeral Service Licenses ames 1701-31 Laurens St. Baltimore, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and Medical a. Subdural hematoma Death Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, ner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED this certificate has been signed by the attending physician director, page 2 should be detached for use as the burial -Division of Vital Records, P.O. Box 68760, Tn the Boapital not Attending Physician: The law requires that the dearh within 24 hours after death.

Tn the Funeral Director: After this completely filled in hours. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown hypertensive cardiovascular disease, end-stage renal disease, diabetes mellitus, Completed 24a. Was an 24b. Were autopsy findings available thrombocytopenia autopsy prior to completion of cause of performed? death? Yes 2 V No 2 No 1 Yes 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 Other: 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) Unknown 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: head injury UNKNOWN 1 Natural 1 Yes 2 V No Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) unknown, , determined (Specify) unknown 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) Medi and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. April 13, 2012 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) APR 1 8 2012 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 6:06P William Allan Tate Apri1 13 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Co. 2 Eddystone Place Apt. Essex 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 220-62-2710 Director 1 🖾 M 2 🗆 F 57 26,1954 Maryland Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City. Town or Location Director Essex MD Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21221 2 Eddystone Place Apt. F 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: an "natural", If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Heating and Elementary/Secondary (0-12) College (1-4 or 5+) Air Conditioning Purchaser 10 Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Virginia F. Williams Robert S. Tate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7972 St. Claire Lane Dundalk, Maryland Terrie Baker (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corp. 4/19/2012 Towson, Maryland 4 Donation 5 Other (Specify) Duda-Ruck Funeral Home of Dundalk, Inc. Michael Neiser 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause x each line. Interval Between Onset and Death Immediate Cause (Final · HOLIZM Physician/ disease or condition Medical resulting in death) atoLOTERS L **Examiner** 617 Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnan ☐ Līve Birth 2 ☐ Fetai deai ☐ Pregnant at time of death 3 Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death igned by the atter be detached for in the past 12 month 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 25. Was case referred to medical 26. Place of Death (Check only one) To Be Other: 4 Nursing Home Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d Describe how injury occurred Certificate: 28c. Injury at Natural work? 5 Pending Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 of certifier 29d. Date signed (Month, Day, Year)

State Registrar

6

30. Name and address of person who co

Sobblice Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale of Sale

Chesto Me, Ballo, MDZ1237

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 23c per doc g926 4-18-12 vt.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death cedent's Name (First, Middle, Last) Date of Death Month **Physician** /Medical acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 **X**M 2 □ F Months Days Hours Min. **Director** 216-62-1804 53 58 09 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show Examiner must be notified at 1√ Yes 2 No Director 28a-f MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code with 1 ō items 23a 21215 U.S.A. 5133 Pembridge Ave Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces?

1√ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 ö 1 ☐ Yes 2√ No Specify. à Black 3 Widowed 4 Divorced Year or Dates: "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) M&M Masionary 12th grade Machine Operator na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental Item 27 is marked o Leiser Cole Calvert Thomas ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5133 Pembridge Ave, Baltimore, Md 21215 Arthur Thomas-Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of h Important: If ite any Injury or ot once. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site 4/15/2012 Baltimore, Md 21. Signature of Funeral Service Licensee March F/H West ale 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the chine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or is a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examiner Aspiration Pneumonia The law requires that the death certificate be executed the burial-transi 1/ that initiated events resulting in death) Last a consequence of) Box 68760, physician Physician/Medical as nding p IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Day for in the past 12 months? Month Year 5 Other (specify) ate has been signed by the at page 2 should be detached to Ves 2 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfor 1 ☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 2 No 2 ER/Outpatient 3 DOA 6 Other (Specify) 1 Tes Inpatient မ this 27. Manner of Feath 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: Injury 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No death. after death Director: A the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation is greatly in the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of 24 hours Hospital 29a. Certifier Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the 29b. Signature and title of certifier Date signed (Month, Day, Year) M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, State 18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 SHIRLEY APRIL **TALLES** 10:15A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE BALTIMORE TOWSON Social Security Number **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Min. Hours (Month, Day, Year, **Director** 217-26-9890 1 🗆 M 2 🗓 F 87 02/28/1925 Usual Residence of Decedent MD show 10a. State 10b. County the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2 X No MD BALTIMORE PIKESVILLE 10e. Street and Number ō 10f. Zip Code is 23a or 10g. Citizen of What Country? Funeral 2 CANDLEMAKER COURT, #204 21208 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural", or ite dical Examiner 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 X Widowed 4 Divorced Specify: Completed WHITE Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) r than Elementary/Secondary (0-12) College (1-4 or 5+) 12 OWNER **JEWELRY** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ျ and 2 should be traumatic TAMRES DORA KARSH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health sitem 27 i BETTYE LEIBOWITZ/DAUGHTER 11107 VERDANT ROAD, OWINGS MILLS, MD 21117 injury or other 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemeters, cremeters or other place)
ARLINGTON CEMETER
CHIZUK AMUNO CONG 4 Donation 5 Other (Specify) 04/15/2012 BALTIMORE, MD SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Parel. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph. sici. n. disease or condition Medical resulting in death) Due to (or as a con quence of) Examiner ٧ معت equentially list conditions. Sequentially list contains, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): as the burial-tran and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Year Pregnant at time of death Month Day ed by the a detached t 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed pinous 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 24 hours after death.
Funeral Director; After this certificate has page 2 autopsy performe Yes 2 Y No Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes ည 2 11/0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

within 2

Hospital

P

State Registrar

Medical

29a. Certifier

only one)

3

29b. Signature and title of certifie

NCHARLES A 701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying, Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ST

BALTIMORE

29d. Date signed (Month, Day, Year)

2012

12-02879 Unk Unk

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State of Maryland / Department of Health and Mental Hygiene 2 1 2

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Physician	/ 1	. Decedent's Name (First, Middle,La					2. Date of Dea Month April 13, 2		3. Time of Death 0109 hrs
Medical Examine		ERWIN ERIC TURN			Tab Ci	ty, Town, or Location of		2012 4c. County of D	
)		a. Facility Name (if not institution, g Johns Hopkins Bayview	give street and number)			Iltimore		N/A	A
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any	_	Sual Residence of Decedent Oa. State 10b. County	10	c. City, Town	or Location				10d. Inside City Limits
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å Pill u		1. Marital Status 1. Never Married 2. Marrie 3. Widowed 4. Divorce			If Yes, sp	pecify Cuban, Mexican,		White, et	tc.
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Baltimo permit. Page Department of Important: injury or ott	1	4 Onation 5 Other Special 1. Solution 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Other 5 Ot	ensee IONATHAN		1 12. Name	and Address of Facility	PHILLIPS F	UNERAL HO	ME, P.A.
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Examiner		mmediate Cause (Final disease or condition resulting in death)	a. Multiple Bl Due to (or as a consequ		rce in	juries			
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760, ficate be g physici s the buri		F FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcome	of pregnancy	Fetal de	eath 3 Ectopic	pregnancy	23d. Date of de Month	livery Day Year
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	erinca	2 X Accident Investig 3 Suicide 6 Could n 4 Homicide	28e. Place of Injur	y - At home, fa	arm, street, fa	ctory, office building, et	28f. Location or Town,	(Street and Number of State) 5600 B1 Baltimore	or Rural Route Number, City ock Of Pulaski ,MD.
Divisi To the Hospital or Att within 24 hours after d within 24 hours after d completely filled in by	_		sician: To the best of my k ner:On the basis of examir and manner stated.						
F 3 F 3	Ĕ	29b. Signature and title of certifier				29c. License number			(Month, Day, Year)
		1/4		u. (u		O.C.M.E.		April 13, 2012	<u></u>
6		30. Name and address of person we Russell Alexander MD.	Assistant Medical		900 W.	Baltimore Street,	Baltimore, MD 2	1223	
Sta Registr	_	31. Date filed (Month, Day, Year)	32. Red shar's	Signature	her	0.1			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2013 P1 armen /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | O 3 / 24 / 1956 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**火** M 2 □ F 56 Yrs Director 213-68-2852 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ntt ff Item 27 is marked other than "natural", or Items 23a or 28a-f show 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Maryland Harford Havre de Grace 1X Yes 2 ☐ No Director notifled 10g Ottized of What Country?

United States of 10e. Street and Numbe 10f. Zip-Code must be 319 Alliance Street 21078 Funeral gerica 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Examiner 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White 2 Specify: 3 Widowed 4 Divorced Year or Dates Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance Maintenance 12 traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carmen Vesper, Sr. Sara Montgomery 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21078 810 S.Washington St, Havre de Grace, MD Carmen Cunningham (sister) other ! 20c. Location - City or Town, State Havre de Grace 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 permit. Pages
Department of
Important: If It
any injury or o Angel Hill Cemetery <u>Maryland</u> 22. Name and Address of Facility Zellman Funeral Home, P.A. 21. Signature of Funeral Service Coense 123 S.Washington St. Havre de Grace, MD 23a. Part 1. Enter the datase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** day emorrhag disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** iver disease Stage End month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) al or Attending Physician: The law requires that the death certificate be executed safter death.

Director: After this certificate has been signed by the attending physician and burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical for use as IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ director, page 2 should be 2 No 3 Probably 4 🗷 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 2 LHC 1 ☐ Yes 2 | No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Impatient ည 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 2 No 1 TYes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

68760, Box PO. Division of Vital Records.

filled in by the funeral within 24 hours hours

State Registrar

4 Homicide

(check only

29b. Signature and title of certifier

29a. Certifier

cal

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) erardo

29d. Date signed (Month, Day, Year) 2012 000

4940 Eastern Avenue, Baltimore, MD, 21224

31. Date filed (Month, Day, Year) APR 1 8 2012

and manner stated.

1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

		Please	e Type or Pr						-		Legible.	
		For State Registrar	State of M	laryland		rtment of I ificate of I		nd Menta		Iene _{eg. No} 2	012	12080
Physicia		1. Decedent's Name (First, Middle, La John Bisbee Walk							te of Deat		12 Year	3. Time of Death 1:45 a M
Medic Examin		4a. Facility Name (if not institution, given The Baywoods of A	re street and number)			4b. City, Town, o				4c. C	ounty of Death	le1
Funeral Director		0 0.1 1.400	Sex 7. Ag	ge (In yrs. las		If Under 1 Year Months Days	If Under 2 Hours	Min. (M	te of Birth onth, Day,	Year)	Cou	nplace (State or Foreign Intry) 1and
aryland ia-f show ified at	ector	10a. State 10b. County MD Anne An	rundo1	10c. City,	Town or Loca	ation						10d. Inside City Limits 1 Yes 2 No
with the M 23a or 28 ist be not	Funeral Director	10e. Street and Number 7101 Bay Front Dr		1 -		10f. Zip Code 21403				og. Citize	en of What Co	
rs after death \ Iral", or items Examiner mu	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?	Ever in U.S.	If	as Decedent of H Yes, specify Cub	an, Mexican,	n? (Specify Ye Puerto Rican,	s or No- etc.)		4. Race - Amer Black, White pecify: Wh:	, etc.
within 72 houl giene. ner than "natu t, the Medical	Scompleted	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)		5+)	(Give ki	ent's Usual Occup nd of work done NOT use retired, ney	during most of	of working			ix Comp	
d be filed Jental Hy arked oth rtic event	To Be	17. Father's Name (First, Middle, Last, William Holcombe	_					's Name (First,		faiden Su	<i>irn</i> ame)	
d 2 should alth and N 27 is ma		19a. Informant's Name/Relationship (John William Walk				Address (Street						Code)
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	☐ Removal from State	20b. Pla	nce of Dispos metery, cremic co Cren ster 22.	ition (Name of atory or other pla ${ t atory}$, ${ t I}$	nc. 0	Date 04/13/20 Cremat:	012 B	alti ocie	more, l	Maryland Maryland,Inc
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Physician/ Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	ne.	LUI	ng c						Interval Between Onset and Death
cate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as									
death certifi ie attending ed for use a	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 Fetal at time of de	death 3 🗌	Ectopic pregnan Other (specify)	су			23	3d. Date of deli Month	very Day Year
ires that th signed by Id be detac	d by Ph	Part II. Other significant conditions	contributing to death	but not resul	Iting in the un	derlying cause g	iven in Part I.	20				the cause of death?
To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Complete							2	4a. Was ar autops perforr Yes	у	prior to death?	opsy findings available completion of cause of
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To the Hospital or Atter within 24 hours after des To the Funeral Director completely filled in by th	al Certificate:	3 Suicide 6 Could not 4 Homicide determined	be 28e. Place of In	jury - At hon tc. (Specify)	ne, farm, stre	et, factory, office			cation (Str ty or Town		Number or Rur	al Route Number,
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To t With To t		29b. Signature and title of certifier	illyco			29c. Licens	e number	8	2	9d. Date	signed (Month	, Day, Year) .012
150		30. Name and address of person who Stuart E.	s completed cause of SCIONIC	death (Item 2	23a) (Type, Pr	int) 03 Me	edical	Pavki	Jay	A	nnapo	.012 lis, Md.
Stat Registra		31. APR 18 2012 ar)	32. Recount	rar's Signatu	Ked .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1 Decedent's Name (First Middle, Last) 2. Date of Death Month L Physician/ Day Medical 4a. Facility Name (if not institution, give street and number) wn, or Location of Death 4c. County of Death Examiner enesis INCOX 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) NC Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Months Hours 226-24-6893 Director 1 🗆 M 💥 🗓 F 12-27-21 90 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21214 USA 6040 Harford Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. African þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced If Yes, Give Specify: American Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) City of Baltimore Housekeeping 8th Grade Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Vastie Dixon George Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 808 G. Briar Hill Place Essex, Maryland 21221 Margie Nicholson-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ★ Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Arbutus Mem. Pk. 04-28-12 Arbutus, MD 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Onset and Death Immediate Cause (Final Ph_sician/ disease or condition 0 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death ed by the a detached f Unknown g Unknow signed by t. d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician: The law page 2 s certificate has autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director. After this completely filled in by the funeral dir Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending Natural iniury 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 📃 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. critifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) re and title of certifier 29b. Signar 29c. License number 29d. Date signed (Month, Day, Year) 2012

Registrar

DHMH 17 Rev 06-2011

1

State

Name and address of person who

8

21075

completed cause of death (Item 23a) (Type, Print)

Medic Examine porothy W22ton 4-11-12 10:55 pm **Funeral Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner

Physician

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

		State Registrar					Cer	tificat	e of De	eatn			Reg. N	0		
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		Physicia Medic		Decedent's Name (First, Middle, Leanning)	Wendy	L	ue	Walı	on_		2. Date of De April	Day 15,	2012	3. Time of Death 1:40 P M
		Examir		4a. Facility Name (if not institution, given	ve street and number)			4b. City, Tow	n, or Locatio	on of Death		4c. Cour	ty of Death	
				Stella Maris Hos 5. Social Security Number 6.				If Under 1 Ye	Timon	ium der 24 Hrs.			Balti	
		Funeral Director		216 66 2640		(in yrs. ia 59	st birthday) Yrs.		lys Hour		8. Date of Bir (Month, Da Oct. 1	th ly, Year) .4,1952	Coun	place (State or Foreign try) inia
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ë.	0036	ural", or al Exami	ted by	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	lo	1	☐ Yes 2🌠	No Spec	ify:		Speci		White
0 p.m.	nd 21215-0036 filed within 72 hours ofter death with the Mendand	han "nat ban "nat	Completed by	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4 or 5+)	(Give F life. D	ent's Usual Oc kind of work do D NOT use retii	ne during m red)		ng	16b. Kind of	Business/Ind ical th Car	,
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•		Medical xaminer		disease or condition resulting in death)	a. BREAST Due to (or as a								\neg	
	-1 2	sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease on Injury	b. Due to (or as a	consequ	ence of):							
W	60 (4) the beex executed	hysician and the burial-transit	dical Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequ	ence of):							
		physic s the b	edic		d									
WALTON	ision of Vital Records, P.O. Box 687 Attending Physician: The law requires that the death certifica	the attending ph	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No g ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	☐ Fetal	Ideath 3	Ectopic pregi Other (specif)					Date of delive Month	ery Day Year
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3	Sords	as been a	Completed								24a. Was	an 24b	. Were autor	psy findings available mpletion of cause of
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 12084 Certificate of Death Reg. No. Middle, Last) 2. Date of Death 3. Time of Death 2:38PM ean Weir muil 14,2012

Months

10f. Zip Code

21061

16a. Decedent's Usual Occupation

Staff Review

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Woodlawn Cemetery

1 ☐ Yes 2X No Specify:

(Give kind of work done during most of working life. DO NOT use retired)

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

75

12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give

10c. City, Town or Location

Glen Burnie

4c

8. Date of Birth

18. Mother's Name (First, Middle, Malden Surname) Susan Mary Schaffer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Bliss Lane, Glen Burnie, Maryland 21060

Date

(Month, Day, Year)

Nov. 9, 1936

County of Death

10g. Citizen of What Country?

United States

16b. Kind of Business/Industry

20c. Location - City or Town, State

04/18/2012 Baltimore, Maryland

Specify:

14. Race - American Indian, Black, White, etc.

White

Baltimore City Police

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

1 Yes 2X No

Maryland

		Please Type or Pri	nt						
		State of Ma	ar						
		State Registrar							
Dhysisian	,	1. Decedent's Name (First, Middle, Last)							
Physician. Medica		Dorothy Jean Weir							
Examine		4a. Facility Name (if not institution, give street and number)	1						
	ú	BALTIMORE WAShinstoNN	9						
Funeral		5. Social Security Number 6. Sex 7. Age	(Îr						
Director		216-26-7444 1 □ M 2 🗓 F Usual Residence of Decedent	7						
show at	0	10a. State 10b. County	1(
laryla	ec.	Maryland Anne Arundel							
or 28	Ē	10e. Street and Number	_						
with with 23a	era	411 Elm Ave							
eath tems	Ē	11, Marital Status 12. Was Decedent E	ver						
6 i, or i	5	1 Never Married 2 Married Armed Forces?	No						
JOS ural" I Exa	led ed	3 ☐ Widowed 4 🛣 Divorced If Yes, Give Year or Dates.							
2 hor	ble	15. Decedent's Education (Specify only highest grade completed)							
thin 7	Ó	Elementary/Secondary (0-12) College (1-4 or 5-							
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	to be completed by runeral Director	12 17. Father's Name (First, Middle, Last)	_						
and be file set o	0	Arthur Foster Nicholson, Jr							
matin		19a. Informant's Name/Relationship (Type, Print)	•						
Ma 2 sh th an trau		Robert E. Weir/ Son							
and Heal		20a. Method of Disposition	Т						
mol age 1 ant of ht: If i		1 X Byrial 2 Cremation 3 Removal from State							
Iltir		4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu of The eral S. We: Licensee	_						
Dep Dep Dep Dep Dep Dep Dep Dep Dep Dep		A A A A A A A A A A A A A A A A A A A							
	_	23a. Part 1. Enter the disease, or complications that caused	th						
Dh. sision (shock, or heart failure. List only one cause on each line Immediate Cause (Final							
Physician/ Medical		disease or condition resulting in death) a. Due to (or as a	2.00						
Examiner		Due to for as a							
	ē	Sequentially list conditions, if any, leading to immediate	1 00						
ted Insit		cause. Enter Underlying Cause (Disease or injury							
xecu n and al-tra	ĭ	that initiated events c. Due to (or as a	C						
be e	25	d.							
376 ficate g phy as the	led		_						
certi andini use	11	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of the past 12 months?	of p						
Box 68760 death certificate be executed the attending physician and ed for use as the burial-transit	200	in the past 12 months? 1 Yes 2 No 9 Unknown	tir						
- C - I !	-								

Licensee Kirkley-Ruddick Funeral Home 421 Crain Highway SE, Glen Burnie, Maryland 21061 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 517515 Due to (or as a conse up METVESON Burs Due to (or as a consequence of) ACIDO813 MITABOLIC Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death a I Inknown B Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 110 မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injun 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: ☐ Natural (Month, Day, Year) 5 Pending Μ 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Fractitionar To the boat of my knowledge, death control at the time, date and plane, and due to the namely) and m 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

State Registrar

Hospital or Attending Physician: The law requires that the Division of Vital Records, P.O.

this certificate

Director: After

24 hours

To the within 2 To the F

filled in by the

MUDICA

es of person who completed cause of death (Item 23a) (Type, Print)

WASHINGION

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BALDMONE

20055703

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 for State Registrar 12085 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month / 04/2012 2100 P M William Milford Whyte Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death 2526 Old Robinhood Road Havre de Grace Harford 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min **Director** 214/26/6441 Usual Residence of Deceden 1 ★ M 2 □ F 82 02/15/1930 Maryland 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 🗌 Yes 2 🔀 No Harford Maryland 10e. Street and Numb Havre de Grace ò 10g. Citizen of Wha United "natural", or items 23a o States of Funeral 2429B Old Robinhood Road 21078 America · death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify White Completed and Mental Hygiene.
Is marked other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Fleet Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta. Inportant: If item 27 is marked any injury or other the process. WIlliam John Whyte Edna Carlisle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William Whyte Jr. (son) 2526 Old Robinhood Rd. Havre de Grace, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State ⊠ Burial 2 □ Cremation 3 □ Removal from State Aberdeen, 04/10/2012 Weslyan Chapel 4 ☐ Donation 5 ☐ Other (Specify) Maryland 22. Name and Address of Facility Zellman Funeral Home, P.A. Signatur Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Washington St., Havre de Grace MD dying, such as cardiac or respiratory arrest,

Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiamyo disease or condition schemic Medical resulting in death) Examiner sanary Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a conseq ence of): burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the IE FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed 2 46 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Lother (Specify) Son's Home မ 1 Inpatient 2 ER/Outpatient 3 DOA this the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certific 29d. Date signed (Morfth, Day, Year

Registrar

DHMH 17 Rev 06-2011

8

State

on who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Nancy Schorah Wesolowski 04/15/2012 0050 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Center Towson 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8 Date of Rirth **Funeral** Days Min Hours 11/17/1950 Maryland **Director** 213-60-1718 1 □ M 2 🗶 F 61 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ Director notified 28a-f Maryland Harford Whiteford 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? F er than "natural", or items 23a or the Medical Examiner must be United States of Funeral 4340 Cooper Road 21160 America
14. Race - American Indian, Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status Armed Forces Black, White, etc. 1 ☐ Never Married 2 🔀 Married 2 X No þ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Accounting Specialist Accounting event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental H
27 is marked ot
traumatic ever Audrey Roberts ည Thomas Schorah, 19a. Informant's Name/Relationship (Type, Print) Chet Wesolowski (husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4340 Cooper Rd. Whiteford, Maryland 21160 of Health a item 27 i other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Havre de Grace ± 5 Department of Important: If any injury or once. 04/18/2012 Gardens Maryland 22. Name and Address of Facility Zellman Funeral Home, P.A. S Washington St Havre de Grace MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pttysician/ taltalia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 SB IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ρ Day Month Year Pregnant at time of death Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of has page 2 autopsy performed? death? 1 ☐ Yes 2 ☐ No 1 Yes 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☐ No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work?
1 ☐ Yes 2 ☐ No 1 Natural 5 Pending s after death. 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Hospital 24 hours Medical 29a. Certifier - certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of oertifier 29d. Date signed (Morth, Day, Year) 29c. License number

Registrar

DHMH 17 Rev 06-2011

State

NCHARLES ST

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

KUMAR

31. Date filed (Month, Day, Year)

D71040

SUITE 4105

12

BACTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State of Man		ırtment of l tificate of l			liene leg. No. 20	12 12087
			Registrar 1. Decement's Name (First, Middle, Last)				Jean	2 Date of Desi		3. Time of Death
	Physicia Medic		JOYCE U	JASHIN	GTOI			Month 5	750	Vear 3 AMM
-	Examin	er	4a. Facility Name (innot institution, give s		÷ 215		r Location of Deat gs Mill		4c. County o	of Death timore
	Funeral		9401 White Ceda 5. Social Security Number 6. Sec	7. Age (Ir.	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth		Birthplace (State or Foreign Country)
	Director		217-50-1452 Usual Residence of Decedent	^{□ M 2 X F 6}	4 Yrs.	Worlding	7,000	03 27		MD
	land show dat	to	10a. State 10b. County	10	Dc. City, Town or Loc					10d. Inside City Limits
	e Mary r 28a-f notifie	Director	MD Baltimon	re _	Owing	gs Mill	s		10g. Citizen of W	1 Yes 2X No
	with th	Funeral	9401 White Ced	ar Dr. Ap	t 215		1117			S.A.
	items items		11. Marital Status	12. Was Decedent Ever Armed Forces?	I	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)		- American Indian,
980	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give X Year or Dates.	1	☐ Yes 2 🔀 No	Specify:			Black
215-0036	2 hours	Completed	15. Decedent's Ed (Specify only highest grad	ucation	(Give I	lent's Usual Occup	during most of wo	rking	16b. Kind of Bus	siness/Industry
2121	ithin 7 iene. r than	Com	Elementary/Secondary (0-12) 12th grade	College (1-4 or 5+) 2yrs		ONOT use retired) unts Re		ative	Bank o	f America
	s should be filed within 72 h and Mental Hygiene. 7 is marked other than "r traumatic event, the Med		17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, I		
Maryland	ould be d Ment marke matic	To	William Dorsey 19a. Informant's Name/Relationship (Ty)	no Printl	40h Mailia	n Address /Ctrast		a Jones		ata. Zin Cada)
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Anthony Washing							wings Mills
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other ti		20a. Method of Disposition 1 XBurial 2 Cremation 3 C	Removal from State		natory or other pla		Date		City or Town, State
Itim	nit. Page artment o ortant: If injury or		4 Donation 5 Other (Specify 21. Signature of Fundal Service Licenter)		King Me	morial Name and Addre		21/2012	2 Woodl	awn, Md
Ba	permit. Departr Imports any inji		All Male	ining D	I M	arch F/	H West	, Balti	more,	Md 21215
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused the cause on each line.	e death. Do not ente	er the mode of dyir	ng, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Bue to (or as a co	Page of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the seco	Cano	9			Onset and Death
	Examiner		Sequentially list conditions,	h	onsequence on,					
,	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	oneaquance or;					
30	execute in and ial-trar	Exa	that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):					
09	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours affer death. Funeral Director. After this certificate has been signed by the attending physician and stell filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical		d						
687	certifica ding p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p	pregnancy				23d. Date	e of delivery
Вох	res that the death certific signed by the attending is d be detached for use as	Completed by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 2 L 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3 me of death 5	Ctopic pregnan Other (specify)	cy		Mon	·
P.O.	at the	, Phy	9 Unknown Part II. Other significant conditions co		not resulting in the u	inderlying cause gi	ven in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
S, P	uires th n signe	ed by						1 🗆 \	es No	3 ☐ Probably 4 ☐ Unknown
corc	sician: The law require certificate has been si irector, page 2 should l	plet						24a. Was a	sy p	Vere autopsy findings available rior to completion of cause of
Re	r: The la		25. Was case referred to medical					1 Yes		eath? Yes 2 No
Vita	ysiciar s certif directo	To Be	evaminer?	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	- Oth	lace of Death (Chiner: $4 \square$ Nursing	Home 5 Resid	ence 6 🗆 Other	r (Specify)
of	ing Phi ifter thi uneral		27. Manner of Death 1 ▶ Natural 5 □ Pending	28a. Date of injury (Month, Day, Y	(ear) 28b. Time of injury	wor	ry at k?		ow injury occurre	
Division of Vital Records,	Attend death ctor A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury	- At home, farm, str		Yes 2 No			r or Rural Route Number,
Divi	tal or /	al Ce	4 - Monticide determined	building, etc. (5	Specify)			City or Tow	n, State)	
	To the Hospital or Attending Physician: The la within 24 hours af effecth. To the Funeral Director After this certificate he completely filled in by the funeral director, page	Medical	(Check 2 Medical Examin	ician: To the best of my ner: On the basis of exar e Practitioner: To the b	mination and/or inves	tigation, in my opin	on, death occurred	d at the time, date a	nd place, and due	to the cause(s) and manner stated.
	To the within 2 To the сотре	Σ	only one) 3 L Certifying Nurs 29b. Signature and title of certifier	e Practitioner; to the b	est of my knowledge	29c. Licens		place, and due to the		(Month, Day, Year)
0			· Chas	On	(11)	1)/	58/0	Z X	fored.	1/2012
	A		30. Name and address of person who c	ompleted cause of deat	th (Item 23a) (Type, F	Print)	Blad	afen.	ByRain	02/06/
	Sta		31. Dap red (Month, 2012ar)	32. Registrar's	Signature		-:			
	Registr	al [100							

68760 P.0. Division of Vital Records,

Baltimore, Maryland 21215-0036

SKIN

Physician

/Medical

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Examiner Social Security Number **Funeral** 219-40-5126 **Director** Usual Residence of Decedent 10a, State show 7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, It a Medical Experiencement to reconstituted at MD Director 10e. Street and Number and 2 should be filed within 72 hours after death with teath and Mental Hygiene. m 27 Is marked other than "natural", or items 23a or : 2434 W. BELVEDERE AVENUE Funeral 11. Marital Status 1 Never Married 2 ☐ Married þ 3 Widowed 4 Divorced Completed Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be HERMAN ဂ္ 19a. Informant's Name/Relationship (Type. Print) Jermit. Pages 1 and 2.
Department of Health an Important: If Item 27 Is many injury or other LINDA CUMMINS/COUSIN 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear trailure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner signed by the attending physician and be detached for use as the burial-transi Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ certificate has been s rector, page 2 should Completed COAGULATION, Hospital or Attending Physician: The hours after death. Funeral Director: After this certificate tely filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M.0 RESIDENT Chanda RES 000 04/13/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAVEN BLVD, BALTIMORE, MD 21204 LOCH Dr. MA AZ THANDA HAN, 5601 31. Date filed (Month, Day, Year) ... aistrar's Signature tate strar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Arnold $\overset{\text{Month}}{A} \underline{p} \underline{r} \underline{i} 1$ $3^{Day}, 2012$ 605 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Genesis Nursing & Rehab Center Charles Waldorf If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Numbe 578–22–2156 6 Sex . Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 0ct 26,1921 **Director** 1**x** x M 2 □ F 90 Washington DC or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If firen 27 is marked other than "natural", or items or other trainments. 10c. City, Town or Location Hughesville ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 10h 10d. Inside City Limits Charles Md 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20637 7087 Bluebird Hill Pl 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Nes 2 □ No If Yes, Give 1941-1945 Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: Completed 3xxWidowed 4 ☐ Divorced Specify:White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Lithographer Dept of Defense Be 17. Father's Name (First, Middle, Last) James Monroe Arnold 18. Mother's Name First Middle, Maidan Surname) ပ 19a. Informant's Name/Relationship (Type, Print) ss (Street and Number or Rural Route Number, City or Town, State, Zin Code) Bluebird Hill PI Hughesville Md 20637 Evelyn Newcomb(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Md Vet Cemetery Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 04/11/2012 Cheltenham Md 4 Donation 5 Other (Specify) ^{22.} Name and Address of Facility Lee Funeral Nome 6633 Old Alexandria Ferry Rd Clinton Md 20735 rvice Licensee MU139 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 1 05V インル Medical Due to (or as a consequence of): **Examiner** REMOTEN TIT Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Vear 2 No ate has been signed by the a page 2 should be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? performe 1 ☐ Yes 2 **X X**No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Hospital 2 X No Other: မ 1 Inpatient 2 Inpatient 3 I After this 4XX Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 🕱 Natural 5 Pending Accident Investigation 1 🗌 Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 50 29b. Signature and title of certifier 29c. License number

Registrar

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 For State Registrar 12090 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ A Month Sherrie Lynn AMATO 0320 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours 214-92-7799 47 Director 1 🗆 M 2 🔀 F March 13,1965 Maryland Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits Director notified 1 X Yes 2 No Hagerstown Maryland Washington 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral items 23a 211 Division Avenue 21740 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. or. þ 1 X Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Health and Mental Hygiene. tem 27 is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the none none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Erik Hansen Amato Janine Marie English 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 223 Fadley Road, Weyers Cave, Virginia 24486 Erik Amato - father 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Hagerstown, Maryland Hagerstown Crematory | 4/6/12 4 Donation 5 Other (Specify) MINNICH FUNERAL HOME Sig a ure of Funeral Service 2. Name and Address of Facility 415 E. Wilson Blvd., Hagerstown, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 5285,5 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** INDMIN S Sequentially list conditions, Strale colitis Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No signed by the a Id be detached f Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 52:341L 1 Yes 2 No 3 Probably 4 Unknown Completed Cerobral Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy Gastroneresi performed' 2 No 1 Yes 2 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Propatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Registrar

Medical

29a. Certifier (Check

31. Date filed (Month,

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (1)

h, Day, Year)

MNN

Régistrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

0000

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Select

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of M	arylan		artment of H		and M	ental Hy	giene	2012		12091
			Registrar 1. Decedent's Name (First, Middle, I	acti		Cer	tificate of E	<i>Jeain</i>	— Т	2. Date of Dea		2012		
	Physicia Medic		NICHOLAS EDWARD							03/30/2		/ Year		3. Time of Death M
والمر	Examin		4a. Facility Name (if not institution, g				4b. City, Town, or	Location o	f Death			County of Dea		
7) 		Medstar Montgom 5. Social Security Number 6			st birthday)	Olney If Under 1 Year	If Under 2	24 Hrs.	8. Date of Birt	_	ontgome		ce (State or Foreign
9.	Funeral Director		212-29-8373	· [Vu o D c	3	Yrs.	Months Days	Hours	Min.	(Month, Day	y, Year)	C	ountry)	
	d 10w	L.	Usual Residence of Decedent 10a. State 10b. County			, Town or Loc	eation			06/04,	/198	8 DC		. Inside City Limits
	arylan ta-f sh ified a	Director	MD Montgo	mery	Olne								100	1 X Yes 2 □ No
	the M	Ϊ́	10e. Street and Number				10f. Zip Code				0	izen of What C	ountry	?
	h with	Funeral	17717 Chipping				20832				USA	·		
10	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	by Fu	11. Marital Status1X Never Married 2 ☐ Marrie	12. Was Decedent E Armed Forces? d 1 \(\sum \) Yes 2 \(\sum \)			Vas Decedent of Hi Yes, specify Cuba					 Race - Am Black, Whi 		
036	ırs afte ıral", (I Exan	ed b	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	340	1	☐ Yes 2 XNo	Specify:				Specify: B	Lacl	2
15-0	2 hou "natu edica	plet	15. Decedent' (Specify only highest			(Give H	ent's Usual Occupa		of workin	g	16b. Ki	nd of Business	s/Indus	stry
121	filed within 72 al Hygiene. I other than ' vent, the Me	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	i+)	Stude:	O NOT use retired)				Sch	001		
pt 2	filed wall Hyg	Be	17. Father's Name (First, Middle, La.	st)		Dedde		18. Mothe	r's Name	(First, Middle,				
ylar	should be file and Mental I is marked o	오	Edward Springer					Clau	idett	e Live	rmor	e		
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship Claudette Ander				g Address (Street a						ip Coc	fe)
more	Page 1 arent of He ent of He nt: If iter ny or oth		20a. Method of Disposition 1 Mag Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Sp		Ce	emetery, cren	sition (Name of natory or other place eaven Cen			/2012		ver Spi		
Balti	permit. Page 1 and 2 si Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service Lic		C7/		Name and Addres	ss of Facility	Sn	owden l		ral Hor		850
			23a. Part 1. Enter the disease, or c shock, or heart failure. List on	omplications that caused	the death								A	pproximate terval Between
	h, sician/		Immediate Cause (Final disease or condition	ATO	2100	hon	- resp	in h		am	54			nset and Death
	Medical Examiner		resulting in death)	Due to (or	a consequ	ence of):					<i>-</i>			
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	ence oi).							1	
	cuted nd transit	xami	cause. Enter Underlying Cause (Disease or injury that initiated events	с.										
	ate be executed bhysician and the burial-transit	dical Examine	resulting in death) Last	Due to (or as	a consequ	ence of):								
760	cate b physi s the b	edic		d										
Box 687	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	Ideath 3	Ectopic pregnanc Other (specify)	:у			120	23d. Date of d Month	elivery Da	ay Year
P.O.	es that the dea signed by the a be detached f	by	Part II. Other significant condition	s contributing to death b	ut not resu	ulting in the u	nderlying cause giv	en in Part I						cause of death?
rds	require been si should	eted												oly 4 Inknown
Division of Vital Records,	The law rate has b	Completed								24a. Was autor perfo 1 \(\sum \) Yes	osy rmed?	prior to death?	comp	findings available letion of cause of
ital	Physician: The this certificate al director, pag	Be o	25. Was case referred to medical examiner? 1 Pes 2 No	Hospital:			Othe	ace of Deat er:						
of V	g Phys er this eral d	e: To	27. Manner of Death	28a. Date of inju	ry	ER/Outpatien 28b. Time of	28c. Injury	/ at		<u>1e 5 ∟ Resic</u> 3d. Describe h		Other (Spe	cify)	
ono	ending eath. or: Afte he fun	ficat	1 Natural 5 Pending 2 Accident Investiga		/, Year)	injury	M 1 □	? Yes 2 🗆	No					
Divisi	al or Atters after de safter de il Directo	Certificate:	3 Suicide 6 Could no 4 Homicide determin				eet, factory, office		2	8f. Location (S City or Tow		d Number or R	ural Ro	oute Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of elurse Practitioner: To the	xamination	and/or invest	igation, in my opinio	n, death oc	curred at t	he time, date a	nd place,	and due to the	cause	
	To the within comp		29b. Signature and title of certifier	PK	71	Med D	29c. License		10			e signed (Mon		
	3		30. Name and address of person wi		eath (Item	23a) (Type, P	Prince	P4:1	Car 1	1- 0	/ne-	20	P. 2	· 2
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra			harres	. , , , ,	7 (-			*

for to ME of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ APRIL 2012 AGNES CATHERINE THOMAS BARNES 4:22 A M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES RESIDENCE. 4135 MILBURN PLACE INDIAN HEAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours MARCH 1, 1930 MARYLAND Director 220-50-5528 1 🗆 M 2 🕱 F 82 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f 1 X Yes 2 No MARYLAND CHARLES INDIAN HEAD 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? must be Funeral 23a 4135 MILBURN PLACE 20640 UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 0 þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify 3 X Widowed 4 Divorced Specify: BLACK Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than dary (0-12) College (1-4 or 5+) 11TH GRADE the HOUSEWIFE HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic every မ WILLIAM MC KINLEY THOMAS EMMA GUTRICK THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AGNES C. BARNES / SELF 4135 MILBURN PLACE, INDIAN HEAD, MARYLAND 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery crematory or other place ST. CHARLES CEMETERY APRIL 9,2012 GLYMONT, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) THORN FON FUNERAL HOME, P.A.
LYDIA C. THORNTON JOHNSON MOO583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the proce of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between 0 20 Onset and Death ANCIEN Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Due to lor as a construence of if any leading to immedicause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the use as IF FFMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) igned by the at signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 performed? Yes 2 XN 2 No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Other: 4 Nursing Home 5X Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After injury 5 Pending work?
1 Yes 2 No Accident Investigation 24 hours after death Funeral Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

within 2

29a. Certifie

(Check

or liv or

29b. Signature and title of certifier

GEORGE H. WATHEN, M.D.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Go thying Nurse Franthiumer: To the period by the wedge, ceath occurred at the time, date and place, and due to the name of an increase.

11345 PEMBROOKE SQUARE, SUITE 103, WALDORF, MD 20603

29d. Date signed (Month, Day, Year)

APRIL 2, 2012

29c. License number

D-20629

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2093 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 2237 April Bernice C. Bartlett Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Davs Hours **Director** 578-46-2441 95 02/18/1917 Pennsylvania Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10c. City. Town or Location Director Silver Spring 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 701 Kerwin Road 20901 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iter Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. 3 X Widowed 4 Divorced WWII White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) U.S. Armu Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be file tment of Health and Mental I tant: If item 27 is marked o Maximillian Becker Clara Rhoa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry M. Bartlett / Step-son 907 West Balsam Street, Libby, Montana 59923 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Department of H Important: If ite any injury or ot 1 Durial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory 04/06/2012 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1232 11800 New Hampshire Ave., Silver Spring, MD 20904 23a: Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Septic Shock Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine nding physician and use as the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day 4 ☐ Pregnant at time of death g ☐ Unknown signed by the at Id be detached fo Yes 2 X No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has k autopsy performed? Yes 2 K No 2 🗌 No 1 🗌 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ※ No Be 26. Place of Death (Check only one) Hospital မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work?
1 ☐ Yes 2 ☐ No ✓ Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 1 🛴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Prantitioner: To the best of my knowledge, death 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D65305 April 02, 2012

Registrar
DHMH 17 Rev 06-2011

State

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1500 Forest Glen Road, Silver Spring, Maryland 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Nabila Khan,

Physician/ Medical Examiner Funeral Director 28a-f show at notified 0 must be 23a items death Examiner ò Maryland 21215-0036 "natural", the Medical than other t should be file and Mental I Department of Health and Ment. Important: If item 27 is marken any injury or over other traumatic Baltimore, Physician. Medical Examiner physician s the burial P.O. Box 68760 use as attending

for State Registrar 2094 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 2012 1:42 pm Maria Baque April 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery Suburban Hospital If Under If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number Months (Month, Day, Year) 218-30-3944 1 🗆 M 2 🗶 F 89 May 05, 1922 Ecuador Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Chevy Chase Maryland Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20815 3202 Cummings Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Black, White, etc. 1 X Never Married 2 Married þ Yes 2 \chi No If Yes, Give Year or Dates 1 ¥ Yes 2 □ No Specify: 3 Widowed 4 Divorced Ecuadoran White. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Own Business Housekeeper 6 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Luis Baque Zenobia Choez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chevy Chase, Maryland 20815 Carmen Suro-Bredie - Friend 5509 Park Street. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Donation 04/05/2012 | Silver Spring, MD Gate of Heaven Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring. MD 20904 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Dreunoung Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1
Yes 2
No Pregnant at time of death 5 Other (specify) be detached been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4X Unknown Division of Vital Records, 1 Yes Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform page 2 1 ☐ Yes 2 ☐ No After this certificate Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's 1 🗌 Yes 2 🔀 No ည 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛎 Natural iniury 5 Pending work? 2 No 2 Accident
3 Suicide
4 Homicide within 24 hours af er death. To the Funeral Director A Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and 29d. Date signed (Month, Day, Year MN 171462 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 8600 Old Georgetown Road, Bethesda, Maryland 20814 <u>Dan Marian Danila,</u> M.D. egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

SAQUE, MARIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 201 - State Registrar Certificate of Death 2 Date of Death Decedent's Name (First, Middle, Last) April 2012 а М 7:30 Physician/ Walter Charles Blaine Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Silver Spring 9417 Wire Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 60 213-48-8082 1 X M 2 🗆 F Director Maryland Aug. 5, 1951 Usual Residence of Decedent 10d. Inside City Limits show 10c. City, Town or Location 10a State should be filed within 72 hours after death with the Maryland Director or 28a-f sl notified 1 Yes 2 X No Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō ms 23a or must be r USA 20901 Funeral 9417 Wire Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?

1 Yes 2 No 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other that any injury or other traumatic event: the M Non-Profit Service Org. Technician 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Esther Margaret Kurtz Charles Burnette Blaine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11505 Cedar Lane, Beltsville, MD 20705 Charles W. Blaine / Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) April 3. 20a. Method of Disposition 1 🔲 Burial 2 🙀 Cremation 3 🗍 Removal from State Alexandria, Virginia Metropolitan Crematory 2012 4 ☐ Donation 5 ☐ Other (Specify) Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 Signature of Funeral Service Licenses Part 1. Inter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Unknown Cardiovascular Disease "Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 12 Years Hypertension Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events signed by the attending physician and Idea be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Year in the past 12 months? Pregnant at time of death Yes 2 No 1 Yes 2 L 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Unknown Hyperlipidemia director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 No has After this certificate 26. Place of Death (Check only one) Be 25 Was case referred to medical examiner? Hospital: Other: 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) မ s after death.

I Director: After this od in by the funeral d 28b. Time of 28d. Describe how injury occurred 28a. Date of injury 28c. Injury at 27 Manner of Death Certificate: (Month, Day, Year) injury 1 X Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 6 Could not be 4 Homicide determined thin 24 hours aft the Funeral Di mpletely filled in Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) within 2 To the I 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title

30. Name and address

31. Date filed (Month,

person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

MD

Ginsberg,

29c. License number

3905 National Drive #220, Burtonsville, MD 20866

D25344

April 2, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

David Micheal Be		State State	of Marylar		artment o		nd Mental F		20	12 12098
Physician		Registrar 1. Decedent's Name (First, Middle,Las	t)		7tillouto o	. 200		2. Date of Dea		3. Time of Death
Medical Examin			Michae1		Be11,			April 7, 20		2011 hrs
		4a. Facility Name (if not institution, given Medleys Nell Road @ Town		ber)		4b. City, Town, of Leonardto	or Location of Dea Wn	th	4c. County of I	
Funeral		5. Social Security Number 6. Se		. Age (In yrs.	last birthday)	If Under 1 Ye	ear If Under 24H	rs. 8. Date of Bi	rth(MM/DD/YYYY)	Birthplace (State or
Director	1	212 27 2662	M 2 F	22	Yrs	Months Da	ays Hours Mi	n. 06/1	2/1989	Foreign Country) Maryland
	t	Usual Residence of Decedent			_					Land traile On Links
w any		10a. State 10b. County			, Town or Loca					10d. Inside City Limits 1 Yes 2 X No
Maryland 28a-f show d at once.	흱	Maryland St. M	lary's		Leonard	10f, Zip Code		1	10g. Citizen of What	Country?
or 28	Director	20601 White Poi	nt Road			206			U S	_
with the ns 23a be not		11. Marital Status	12. Was Deced			as Decedent of H	lispanic Origin? (0- 14. Race - /	American Indian, Black,
death with the Maryland or items 23s or 28s-f sho must be notified at onc.	Funeral	1 X Never Married 2 Married	1 Yes	ces? 2 X No			an, Mexican, Puerl	o Rican, etc.)	White,	
s after rral",	اھ	Widowed 4 Divorced 15. Decedent's Education (Specify or	If Yes, Give Year or Dates:	completed)	1	Yes 2X N	lo specify: pation (Give kind of	work done	Specify: 16b. Kind of Busir	White ness/Industry
2 hour	ied ed	Elementary/Secondary (0-12)	College (1-4				fe. DO NOT use re		TOD. Raid of Busin	1000/maddu y
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5-0 iled w Hygie I othe	ပေျ	17. Father's Name (First, Middle, Last		0-11 4	·		100		Maiden Surname)	P1 and
2121 ould be fill Mental F marked c event, et	Be	David Micha 19a. Informant's Name/Relationship (1		Be11, S		a Address (Str	Kimber		Rose mber, City or Town,	Floyd State, Zip Code)
MD 2 shoulth and M 27 is numstic	유	DavidM. Bell, Sr		c					ardtown,	
	ŀ	20a. Method of Disposition			Place of Dispos crematory or of	sition (Name of c	cemetery,	Date	20c. Location - C	ity or Town, State
Baltimore, permit. Pages I ar Department of Her Important: If ite		1 Emerial 2 Cremation 3 4 Donation 5 Other Specify				emorial	Grd. 4	/12/2012	Leonar	dotnw, MD
Salti smit. epartm nports		21. Signature of Funeral Service Licer		- \	22. 1	Name and Addre	ss of Facility Ley-Gard	iner Fun	eral Home	, P.A.
		Muchael # 23a. Part I. Enter the disease, or comp	Jardes	red the death	i	41590 Fe	enwick St	:., Leon	ardtown,	MD 20650
Physician ./Medical	-	failure. List only one cause on ea	ach line.				8,	. , , с о р ,		Between Onset and Death
Examiner	-	Immediate Cause (Final disease a. or condition resulting in death)	Head and Ne							
		Sequentially list conditions, b.								
	틸	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a c	onsequence (or):					
ed sit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence (of):					
xecul n and 1 - tra	edical	d. UNPENDED	AMENDED							
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: 6876(certificate anding phy use as the b	a I	23b. Was decedent pregnant in the past 12 months?	1 Live birt	th nt at time of d		etal death 3	Ectopic pregi	nancy	Month	Day Year
Box e death c the atten	Physici	1 Yes 2 No 9 Unknown			eath 5 O	ther (Specify)				
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ord: Iw requas been as been 2 shoul	Completed							24a. Was	psy prid	ere autopsy findings available or to completion of cause of ath?
	န္ပြ							1 Yes		Yes 2 No
Vital ysician his certification	8	25. Was case referred to medical examiner?	Hospital:	patient 2	ER/Outpatien		ce of Death (Chec		Residence 6	Other: Scene
- d 1 2 2 1	잂	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of	f Injury	28b. Time of		jury at Work?	28d. Describe	how injury occurred	1
- = . ~ € l	Certification:	1 Natural 5 Pending	Apr 7, 20	ay, Yaar) 12	1950 hrs	1	Yes 2 V No	Driver of au	ito involved in o	collision
Division rate of a brack.	<u>2</u>	2 Accident Investigat 3 Suicide 6 Could not	be 28e. Place	of Injury - At I	nome, farm, stre	et, factory, office	building, etc.	28f. Location (or Town,		or Rural Route Number, City
Divi	ह	4 Homicide determine	(0,000))	Local Stre				Medleys Nell	Road @ Tower I	Hill Road, Leonardtown, M
8 - 5 > 1		Chearany	r:On the basis of	examination					ise(s) and manner a and place, and due	
Tot with Tot	Medical	29b. Signature and title of certifier	and manner sta				nse number	.		(Month, Day, Year)
		0 1	11			0.0	C.M.E.		April 8, 2012	
3		30. Name and address of person who								
deme						Baltimore St	reet, Baltimor	e, MD 21223		
Sta Registr	_	31. Date filed (Month, Day Year)	2 2. Reg	istrar's Signal	are day	Las 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 20<u>12</u> Physician/ 7 2:07 p.nM April Edward Robert Baroniak Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mary's Hospital Leonardtown Mary's 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 XM 2 □ F Months Davs Hours Min Director Maryland 220-16-8004 86 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location with the Maryland Director must be notified 1 🗌 Yes 2 💢 No Maryland St. Mary's Lexington Park 10g. Citizen of What Country? 10f. Zip Code ь 10e. Street and Number Funeral items 23a United States 48209 Mattapany Road permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 ☐ Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Owner Excavating Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٥ John Frank Baroniak Anna Matty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48202 Mattapany Road, Lexington Park, MD 20653 Judith Tennyson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Brinsfield-Echols Cre 04/11/2012 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lio has multiple Brinsfield Funeral Home, P.A. Danielle Ward M01403 Hollywood Road, Leonardtown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1 inute disease or condition Medical resulting in death) Due to (a as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or ate consequence of Cause (Disease or linjury that initiated events certificate be executed and Due to (or as a consequence of): resulting in death) Last physician are the burial-t Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? requires that the death Month Day Pregnant at time of death 5 Other (specify) P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Récords, Completed 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an The law autopsy performe has certificate Vital or Attending Physician: 25. Was case referred to medical funeral director, To Be 26. Place of Death (Check only one) examiner' Hospital Other: 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Manner of Death 28a. Date of injury (Month, Day, Year) of 28b. Time of 28c. Injury at work?
1 \(\sum \) Yes 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending Division 2 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide determined the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examination and/or investigation in an arrival and the state of the cause of examiners and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the sta Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Mo

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Ponia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Mary		tificate of L			Reg. No.	2 2098
	Physicia Medic		1. Decedent's Name (First, Middle, La: JAMES B	ERNAP.	S BR	COMM	E	2. Date of Dea	Day 20	3. Time of Death
	Examin		4a. Facility Name (if not institution, give				Location of Death		4c. County of	
The second	Funeral		Howard County 5. Social Security Number 6. S		yrs. last birthday)	Colu	mbla If Under 24 Hrs.	8. Date of Birtl		ward 9. Birthplace (State or Foreign
	Director		157-28-6140	X M 2 □ F	Vro	Months Days	Hours Min.	(Month, Day 10/11/1	v, Year)	Country) Scotland
	ld now at	_	Usual Residence of Decedent 10a, State 10b, County	1100	71 Trs.	cation		μ0/11/1	940	10d. Inside City Limits
	arylar a-fsh ified a	Director	MD Howard		Colum					1 🗆 Yes 2 🔀 No
	the M or 28 e not		10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	n with	Funeral	9501 Sylvan De	11		21	045		Unite	d States
	r death		11. Marital Status 1 ☐ Never Married 2★ Married	12. Was Decedent Ever in Armed Forces?	in U.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
21215-0036	e filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show ed other than matural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	3 Widowed 4 Divorced	1 Yes 2 Mo If Yes, Give Year or Dates.	1	☐ Yes 2X No	Specify:		Specify:	White
2-0	2 hour	plet	15. Decedent's E (Specify only highest gr		16a. Deced	lent's Usual Occup	ation during most of work	ina	16b. Kind of Busi	ness/Industry
121	ene. than the Me	Com	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do	0 NOT use retired) lanager			Social So	ecurity Admin.
	filed within all Hygiene. d other tha	Be	17. Father's Name (First, Middle, Last)		<u></u>	iai iagei	18. Mother's Nam			scarrey Admin.
/lan	0 2 3 0	၀	Neil Browne				E11	en Dohe	rty	
, Maryland	har har 7 is		19a. Informant's Name/Relationship (7 Rosemary Browne			ng Address (Street a 01 Sylvan	and Number or Rura Dell C	al Route Number Columbia		
altimore,	t of t of If ii		20a. Method of Disposition 1 → Burial 2 ☐ Cremation 3	Removal from State	0b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	:e)	Date	20c. Location - C	
Hir	permit. Page Department o Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Special Service License)		St. Loui			.0/2012	-	sville, MD
Ba	Depar Impor any ir	- 3	A	- With						Family FH Inc. ty, MD 21043
	Physician/		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause op ach line.	death. Do not ente		g, such as cardiac o	or respiratory am	est,	Approximate Interval Between Onset and Death
4	Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of):	n Z	7A57	ACE		
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Disc to for as a nor		70,0		- / / -		
	cate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events	c						
_	icate be executed physician and is the burial-trans		resulting in death) Last	Due to (or as a cor	isequence oi).					
120		l edical		d						
. Box 68	death cert	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 Live Birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnance Other (specify)	cy		23d. Date Monti	,
s, P.O.	The law requires that the atte has been signed by the page 2 should be detach		Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u $3F/ou$	nderlying cause giv	ven in Part I.			ute to the cause of death?
ord	v require been signal	Completed by				Am/	UT=/10	24a. Was a		re autopsy findings available
3ec	sician: The law scrifficate has birector, page 2 s	mo						autop perfor 1 Yes	rmed? de:	or to completion of cause of ath? Yes 2 No
ta	ysician: s certifica director,	Be C	25. Was case referred to medical examiner?				ace of Death (Check			
ίV	> 00	은	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of injury	2 ER/Outpatien		4 ☐ Nursing Ho		ence 6 Other	Specify)
o u	nding lth. : After e funei	cate	1 Natural 5 Pending 2 Accident Investigatio	(Month, Day, Yea		work		28a. Describe no	ow injury occurred	
Division of Vital Records,	Hospital or Attending Physician: 44 hours after death: 424 hours after death: Funeral Director. After this certificately filled in by the funeral director.	Certificate:	3 Suicide 6 Could not be determined			eet, factory, office		28f. Location (S City or Town		or Rural Route Number,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director, After thi completely filled in by the funeral	Medical	(Check 2 🖂 Medical Exam	sician: To the best of my kiner: On the basis of examines Practitioner: To the best	nation and/or invest	tigation, in my opinic	on, death occurred a	t the time, date ar	nd place, and due to	the cause(s) and manner stated.
	To the within 2 To the comple		, , , , , ,	by no		29c. License	3587		29d. Date signed (1	Month, Day, Year)
			30. Name and address of person who	PL, Su	15 3C	BAL	TIMO	BRU	, wo	
	Star Registra	te ar	31. Date filed (Month, Day, Year) 4 20	32 Registrar's S	B. A.	ake				

you to MEIN

12-02776 Jed Ryan Bylsma Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2

		1- For State Registrar	Cert	tificate of	Death			eg. No.	
Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last) Jed Ryan Bylsma					2. Date of Dear Month April 9, 20	Day Year	3. Time of Death 0155 hrs
		4a. Facility Name (if not institution, give st EB Ocean Gateway near Air			4b. City, Town, or Easton	Location of Dea	ath	4c. County of Talbot	Death
Funeral Director		5. Social Security Number 213-17-0600 6. Sex	7. Age (In yrs. Ia 2 F 30	st birthday) Yrs	If Under 1 Yea Months Day		8. Date of Bir 08/17/	th(MM/DD/YYYY) 1981	Birthplace (State or Foreign Country)
d towany		Usual Residence of Decedent 10a. State 10b. County PA Adams	10c. City,	Town or Locati					10d, Inside City Limits 1 Yes 2 X No
with the Maryland ns 23a or 28a-f show be notified at once.	Director	10e. Street and Number 771 Barlow Drive			10f. Zip Code	325	11	0g. Citizen of Wha	at Country?
r death or iter	by Funeral	1 Never Married 2 Married 1 3 Widowed 4 Divorced If You	Dates:	- If Y	es, specify Cubar		Specify Yes or No- to Rican, etc.)	White,	white
5-0036 led within 72 hours afte Hygiene. I other thao "oatural", the Medical Examiner	Completed t	15. Decedent's Education (Specify only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmonic only harmo	ighest grade completed) College (1-4 or 5+)	during me	t's Usual Occupa ost of working life e Office1	DO NOT use r		16b. Kind of Bus Law Enfo	
	B		T. Bylsma	Jaco	ne (First, Middle, M queline G	unner			
and and	2	19a. Informant's Name/Relationship (Type Jacqueline G. Bylsm	a/ mother	771 Ba	rlow Dr	ive Geti	r Rural Route Num tysburg,	PA 17325	
Baltimore, MC Demit. Pages 1 and 2 s Department of Health an Important: If item 27		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State	rematory or oth			Date 4-10-2012		ourg, MD 21783 neral Home
Baltimo permit. Page Department of Important: injury or ot		21. Signature of Funeral Service Licensee	Maur .	91	Willis	Street	Westmins	ter, MD	21157
Physician Victimal Examiner	9			or respiratory arre	est, shock, or hear	t Approximate Interval Between Onset and Death			
		Sequentially list conditions, b	to (or as a consequence of						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	to (or as a consequence of) to (or as a consequence of)						
760, ficate be executed g physician and the burial - transit		dd	MENDED					<u> </u>	
lox 68 leath certil		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	=	2 Fet	ial death 3	Ectopic preg	nancy	23d. Date of d Month	lelivery Day Year
ires that the d signed by the	2	Part II. Other significant conditions con	stributing to death but not re-	sulting in the u	nderlying cause (given in Part I.			ute to the cause of death? Probably 4 Unknown
of Vital Records, P.O. g. Physiciae: The law requires that the this certificate has been signed by neral director, page 2 should be detax	Completed			-	· · ·		24a. Was a autop: perfor	sy pri m <u>ed</u> ? de	ere autopsy findings available for to completion of cause of ath? Yes 2 No
ital Recions: The scertificate rector, page	Be	25. Was case referred to medical examiner?	ital: 1 Inpatient 2	ER/Outpatient		Other Nurs		Residence 6	Other Seems
of Vital iog Physicino: After this certifi funeral director,	일	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year) Apr 9, 2012	28b. Time of Ir		ry at Work?		now injury occurred	,
Sion Attend death. ector:	Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	Apr 9, 2012 28e. Place of Injury - At ho	0155 hrs me, farm, stree		Yes 2 V No	28f. Location (S	treet and Number	or Rural Route Number, City
Divis C Hospital or A 124 hours after c Fuoeral Dire		4 Homicide determined	(Specify) in vehicle				1	teway near Airp	ort Road, Easton, MD
Di To the Hospital within 24 hours a To the Fuoeral I completely filled	Medical	(Check only one) 2 Medical Examiner: On and	To the best of my knowledg the basis of examination an manner stated.		ion, in my opinior	n, death occurred		and place, and du	e to the cause(s)
	Σ	29b. Signature and title of certifier	I.Mo		29c. Licens O.C.			April 9, 2012	d (Month, Day, Year)
10 By		30. Name and address of person who com Melissa Brassell, MD Assis	pleted cause of death (Item stant Medical Examin	,	. Baltimore S	street, Baltim	ore, MD 2122	3	
St Regist		31. Date filed (Month, Day, Year) APR 1 7 2012	32. Registrar's Signatur	backer					

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2012 12100 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1330 Brakeall Diane Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cumberland Allegany WMHS-RMC 9. Birthplace (State or Foreign Country) MD Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min. (Month, Day, Year) 1960 Jun 14, 1960 215-80-0375 Usual Residence of Decede Director 1 🗆 M 2 🗆 XF an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 57 E. Offutt Street 21502 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify. white Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12 <u>homemaker</u> own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Josephine A. Lechliter James Daniel Ricewick, Sr. permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code MD 21502 Dale Brakeall husband 57 E. Offutt Street Cumberland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Kremation 3 ☐ Removal from State 4/4/2012 Cresaptown MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final trauma40 Physician/ disease or condition resulting in death) Medical Examiner MICHAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) Month Day 1 Yes 2 I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No **Division of Vital** 25. Was case referred to medical To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ဂ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

e Funeral Director: After pletely filled in by the fun HUNG 1 Yes 2 4 NO Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number Mullillet D53158 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Schon Drive Combilland 31. Date filed (Month, Day, Year)
APR 1 7 2012 32. Registrar Signature Registrar

DHMH 17 Rev 06-2011

Box 68760

P.O.

Please Type or Print in Black Indelible Jak. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Richard Lee Blamble 14 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett Garrett County Memorial Hospital Oakland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1X M 2 □ F Months Days Hours Country D5%01°%1°9°40 71 234-64-3619 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director WV 1 Tes 2 No Preston Aurora 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1003 Snyder Hollow Road 26705 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 10 Ford Motor Co. Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elwood Brown Blamble Hazel Anna Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Blamble/Wife 1003 Snyder Hollow Rd. Aurora, WV 26705 20a. Method of Disposition 20c. Location - City or Town, State Sub Place of Disposition (Name of a 1 temperal, cremator) of Timer place 1 Durial 2 X Cremation 3 Demoval from State Crematory 03/14/2012 Kingwood, WV Gardens 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hinkle Funeral Home, Inc. . Signature of Funeral Service Licensee & Scott fink P.O. Box 186 Davis, WV 26260 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final 2mbo Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months? Month Day n signed by the a 1 Yes 2 9 Unknown 2 No P.O. II. Other significant conditions contributing to death but not resulting in the underlying-cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician; The law requires Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an per has autopsy IP perform after death.

Director: After this certificate Won 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 064302 3-14-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- 7 5 5 N 5 ... Stife 1 Oakland, MD 21550 Daniel Buckingh 20 32. Regis 31. Date filed (Month, Day, Ke State Registrar

O DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Dahlia Buffone 2012 30 5:45 P March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frostburg Village Nursing Care Ctr Frostburg Allegany If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X**□ F oct. 13, ,^{Year}1918 Country Director 187-14-6386 93 Usual Residence of Decedent 3a or 28a-f show t be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f shoiury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Frostburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Kaylor Circle 21532 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Rosino Panippucci (Unknown) မ Vincenzo Panippucci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory Skidmore 100 S. Liberty St., Cumberland, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of H Important: If ite any injury or ott 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenwood Mem. Park Apr. 4, 2012 Lower Burrell, PA Signature of Funeral Service Licensee 22. Name and Address of Facility Hafer Funeral Service, PA ohn 1302 National Hwy., LaVale, MD 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ CHRONIC OBSTRUCTIVE LUNC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consecuence of burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be P.O. Box 68760 IE FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Year 9 Unknown this certificate has been signed by the ral director, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARKINSUNISM To the Hospital or Attending Physician: The law requires: bythin 24 hours after death.

To the Funeral Director: After this certificate has been sign Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No pleted filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No injury 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

026907

BISHOP WALSH RD. CUMBERLAND, MD Z1502

29d. Date signed (Month, Day, Year)

James	Michael	Chastain
		1- For S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

ames Michael		I- For State		tment of ificate of		and Me	ental Hy	_	201	2 12103		
Mont							2. Date of Deat Month		3. Time of Death			
Medical Exami	ner	JAMES MICHAEL CHAST 4a. Facility Name (if not institution, give street and num	2012 4c. County of De	1227 hrs								
		Route 213 @ Lloyds Meadow	Del)	"	c. City, Town Centervil		on or peaci		Queen Anne			
Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. las	t birthday)	If Under 1			8. Date of Birt	h (MM/DD/YYYY) 9. i			
Director		409-98-7310 1XM 2□F	56	Yrs.	Months [Days Ho	ours Min.	10/24/	1955	eignTENNESSEE Country)		
any .	-	Usual Residence of Decedent 10a. State 10b. County	10c City T	own or Locatio	n					10d, Inside City Limits		
. ₹	Ļ	MD QUEEN ANNE'S		STEVENS						1 Yes 2 X No		
Maryland 28a-f show i at once.	Director	10e. Street and Number			10f. Zip Cod	е		10	g. Citizen of What Co	ountry?		
with the Maryland ns 23a or 28a-f abo be notified at once		909 MAY LANE			2166	6			UNITED STA	ATES		
th with	Funeral	11. Marital Status 1 Never Married 2 Married Armed Force				Origin? (Spe	ecify Yes or No- Rican, etc.)	14. Race - Am White, etc.	erican Indian, Black,			
er dea										HITE		
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	d b	15. Decedent's Education (Specify only highest grade	completed) 1	l6a. Decedent's	S Usual Occu	pation (Gi	ive kind of wo		16b. Kind of Busines			
6 172 ho cal Ex	ete	Elementary/Secondary (0-12) College (1-4	or 5+)	-	-		OT use retire	ed)				
withir spene.	Completed	12 17. Father's Name (First, Middle, Last)		TRUC	K DRIV		hada Nama /	First Middle N	GROG	CERY		
215- e filed ral Hyg red orl	Bec	JAMES CHASTAIN						NE GULL				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	Address (Si				ber, City or Town, Sta	ate, Zip Code)		
MC at an alth an 27 in 27 in an		MILTON C. ARMES/FATHER IN 20a. Method of Disposition		8716				COURT,	ODENTON, 1			
Baltimore, permit. Pages 1 at Department of He Important: If ite		1 Burial 2 X Cremation 3 Removal from	State CHES	TAPEAKE	CREMA	TION						
it. Pag rriment primet		4 Donation 5 Other Specify: 21. Sanatyre of Funeral Service Licensee		CENTE	R				STEVENSVI			
Depa Inip	ļ	CL M. +12	<u>·</u>	FEL.	LOWS,	HELF1	ËNBEIN ROAD	& NEWN	AM FUNERAL , MD 21619	L HOME, P.A.		
Physician		23a. Part I. Enter the disease, or complications that cau failure. List only one cause on each line.	sed the death. D	o not enter the	mode of dyi	ng, such a	s cardiac or	respiratory arre	est, shock, or heart	Approximate Interval Between Onset and		
Examiner Immediate Cause (Final disease a Multiple Injuries									Death			
_		or condition resulting in death) Due to (or as a consequence of): b.										
	edical Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause										
		Colleges or injury that hit add events resulting in death) Last Due to (or as a consequence of):										
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O, be execut sician and burial - tra		UNPENDED AMENDED										
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ox 6 ath cer attendi	Physician/M	4 Pregnan	t at time of deat	h 5 Othe	r (Specify)					ļ		
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30. Name and address of person who completed cause of death (Nem 23a)												
0 [119		Zabiullah Ali, M.D. Assistant Medical	,	900 W. Ba		treet, Ba	altimore, M	MD 21223				
St Regis	ate rar	31. Date filed (Month APR. Year) 2012 32. Resi	strar's Signature	6. par	Kar							

Callaway, Hazel M.

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Me	Examiner 4a. Facility Name (if not institution, give street and number) Memoral Hospital 4b. City, Town, or Location of Death TAN									2012				
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Mec	(Check only one)	3 Certifying	g Nurse Practitioner			, death occurred at t	he time, da			the cause(s) and	manner a		
5 with		29b Signature ar	nd title of certifie				29c. License		260		29d. Date sign		n, Day, Year)	
(att		30. Name and ad	dress of person	who completed caus	e of death (Item	n 23a) (Type, F	Print)				- 1	210	5 S. Washinsti	
	_ _	DAVID	C-	WHITE, M	D EM	ergence	Print) Pept, E	aston	Men	nerial k	tospital	57.	265ton, 0 VID 2/6/9	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 30 Pay 2012 4:56 A Charlotte Josephine Chew Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Country Companions Asst Living Taneytown If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. August 32ay, Years 34 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 M F Maryland 215-32-1020 77 Director Usual Residence of Decedent or 28a-f shov 10a, State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director Carroll MD Taneytown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3217 Bert Koontz Rd 21787 United States hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marita Status 14. Race - American Indian, Armed Forces? Black, White, etc. White 1 Never Married 2 Married þ 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) il Hygiene. I o**ther than** " Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygie is marked other Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alice Williams Harry Chew or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3217 Bert Koontz Rd, Taneytown, MD 21787 permit. Page 1 and 2 st Department of Health a Important: If item 27 is Judy Gagnon, Guardian 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State injury o Pleasant Cem. 104/03/12 4 Donation 5 Other (Specify) Mt. Gamber, MD 21. Signature Funeral Service Lice 22. Name and Address of Facility any Myers-Durboraw FH,136 E Balt, Taneytown MD 23a. Part 1. Enter the disease, or complications that caused the death, i o not enter the mode of dying, such as calling an respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on e line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Litter Unidentying Cause (Disease or iinjury Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Month Year Pregnant at time of death ed by the a detached f 9 Unknown cate has been signed page 2 should be det Part II. Other resignificant conditions of tributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an Hospital or Attending Physician: The law autopsy certificate within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence မ 1 Inpatient 2 ER/Outpatient 3 DOA Other (Spec 28a. Date of injury (Month, Day, Year) eath 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 27. Manner of 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation Suicide
Homicide 6 Could not b Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determine d Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one and title of certifie 29b. Signatur 29d. Date signed (Month/Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 2. Date of Death 1. Decedent's Name (First, Middle, Last) .Day2012 March 28, 6:02P Physician/ Cook Wanda Μ. Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel Annapolis 906 Perry Landing Court Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Days **Funeral** Months MD 1 M 2 X F 91 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If firem 27 is marked other than "natural" or the frame any injury or other trainment. 10a. State 10b. County Director 1 🗌 Yes 2 🗓 No Annapolis Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 21401 906 Perry Landing Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Completed by White 1 Yes 2 X No Specify: 3 XWidowed 4 Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Tele hone Com any Supervisor 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ္ Apolonia Gwarda Wladyslaw Weglicki 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 906 Perry Landing Court, Annapolis, MD 21401 <u> Cathryn M. McPartland/Daughter</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State Edgewater, MD 3-30-2012 Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Fund I vervice Licensee 2973 Solomons Island Rd., Edgewater, MD 21037 001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Day Month in the past 12 months? 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 X N 2 🗆 No 1 TYes 26. Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Be examiner?
1 Yes 2 X No Other: Hospital 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at work? 28b. Time of 27. Manner of Death 1 X Natural Certificate: injury Director: After 5 Pending 1 Yes 2 No Investigation
6 Could not be ☐ Accident ☐ Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours a To the Funeral I Medical 29a. Certifier (Check only one; 29d. Date signed (Month, Day, Year) nd title of certifier 29b. Signature 330 H4696 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salome Hawkins Cile DO 4 East Rolling Crossicals, Sulte 307, Bultimore MD 21328

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, APR ar 0 3 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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I	Physicia Medic		1. Decedent's Name (First, Middle, Last) Richard C. Cullers		2. Date of Death 049002/20192	y Year 3. Time of Death 11:20 M					
	Examin		4a. Facility Name (if not institution, give street and number) 450 Poplar Lane 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Annapolis If Under 1 Year If Under 24 Hrs.		County of Death nne Arundel					
	Funeral Director		578-36-8698 Usual Residence of Decedent 1	Months Days Hours Min.	(Month, Day, Year) 08/18/1930	9. Birthplace (State or Foreign Country) Virginia					
	ne Maryland or 28a-f show notified at	To Be Completed by Funeral Director	MD Anne Arundel Annapol 10e. Street and Number 10c. City, Town or Lo	is		10d. Inside City Limits 1 ☐ Yes 2 X No					
	1 and 2 should be filed within 72 hours after death with the firementh and Mertal Hygiene. The firem 27 is marked other than "natural", or items 23a of them 27 is marked other than "natural", or items 23a of the traumatic event, the Medical Examiner must be			10f. Zip Code 21403		izen of What Country? USA					
9800			1 Never Married 2 XMarried 1 Test 2 No If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto I ☐ Yes 2XXNo Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White					
21215-0036			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) C&P	ind of Business/Industry Telephone							
Maryland			17. Father's Name (First, Middle, Last) Kauffman Cullers	18. Mother's Name Louise	e (First, Middle, Maiden Surname) Murphy						
Mar				ng Address (Street and Number or Rura Poplar Lane Anna:							
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, crem	sition (Name of Inatory or other place)	Date 20c. Lo	ocation - City or Town, State					
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of June at Service Licensee	Name and Address of Facility ardesty Funeral H	ome P.A. An	Ridgely Ave napolis,MD 21401					
	Phylician Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. England failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failure for the failur	er the mode of dying, such as cardiac of	Approximate Interval Between Onset and Death						
	Examiner	ıer	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):								
		Examiner	if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):								
092	cate be e physicia s the bur	Medical Certificate: To Be Completed by Physicia	d								
. Box 68760	sician; The law requires that the death certificate be executed certificate has been signed by the attending physician and riector, page 2 should be detached for use as the burial-transit.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal death 3 □ 2 □ Fetal deat		23d. Date of delivery Month Day Year						
ds, P.O	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans.		Part II. Other significant conditions contributing to death but not resulting in the u	se contribute to the cause of death?							
Division of Vital Records, P.O.	Ine law req cate has bee page 2 sho				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No					
Vital	ysician is certifi directo		25. Was case referred to medical examiner? 1								
n of	ding Ph th. : After th s funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time of injury injury	28c. Injury at work? M 1 ☐ Yes 2 ☐ No							
Divisio	or en cospinal or Attending Priysician, within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director.		3 Sulcide 6 Could not be 4 Homicide 6 determined 28e. Place of Injury - At home, farm, streed building, etc. (Specify)								
	To the Hospital within 24 hours To the Funeral completely filled		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	To the within To the Comple		29b. Signature and title efficient of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the proper	29d. Date	29d. Date signed (Month, Day, Year) 4 2 12						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles W. Phylomo, 139 Old Solomons Island RD., Annapolis MD 2140,										
Ä	Stat Registra	-	31. Date filed (Month, Day, Year) APR 0 3 2012 32. Registrar's Signature	all							
		011									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March Physician/ Larry 2012 10:28A M Neal Cannon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9336 Ocean Gateway Easton Talbot If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 X M 2 🗆 F 66 Mav 22 217-44-1813 Yrs. T945 **Director** Md. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Md. Talbot 1 X Yes 2 □ No Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9336 Ocean Gateway 21601 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, rmed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Army Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Utilities Commission Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Wm. John Sarah Neal Cannon, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryanne Izaguirre/ Daughter 5940 Newton Rd. Preston, Md. 21655 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 03-31-2012 Delmar. 4 Donation 5 Other (Specify) Crem. of Delmarva Signature of Funeral Service Licenses Hurtey & Ostrowski Funeral Home P.A. P.O. Box 518 St. Michaels, Md. 21663 Joseph) trowski 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line OCAYDIAI Immediate Cause (Final Inforction Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of):) physician and is the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ Unknown the a Unknown After this certificate has been signed by in funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

10+IVARS

State Registrar

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

Jorge Abrego M.D. 598 Cynwood Drive Ste. # 104 Easton, Md. 21601 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 27 2012 MARGARET ELIZABETH CLARK 10:10 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TALBOT HOSPICE HOUSE EASTON TALBOT 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Min Director 189-36-3225 92 1 □ M 2 🗓 F 12/10/1919 PENNSYLVANIA 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified TALBOT TILGHMAN 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21426 AVALON COURT 21671 USA "natural", or items edical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: WHITE 1 Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) ELEMENTARY SCHOOL TEACHER EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ၉ MAX STEINWACHS MARY JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 is STEPHANIE SOKSO/DAUGHTER 21426 AVALON COURT TILGHMAN, MD 21671 Department of Healt Important: If item 2 any injury or other: 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) FAIRVIEW CEMETERY 04/04/2012 COATESVILLE, PA 21. Signature of Funeral Service Licenses LOWS TH ress of Facility IEL FENBEIN HARRISON STREET EASTON, MD 21601 MERCE JOHN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition mo Medical resulting in death) Due to (or as a consequence of) Examiner 9 mo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury I managy Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 as the l IF FEMALE: nse yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Investigation 6 Could not be 2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) CANU 126/98 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R53 CKNP -

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 04/01/2012 7:35P John Bentz Carroll Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospita Rockville If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Social Security Number Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F 205-10-8969 93 05/07/1918 **Director** Pennsylvania Usual Residence of Decedent or 28a-f show notified at 10a. State 10h Count 10c. City, Town or Location Director 10d. Inside City Limits Montgomery Potomac MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a o Examiner must be Funeral 11809 Gregerscroft Road 20854 United States death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces
1 Ares 2 If Yes, Give þ Black, White, etc. 1 Never Married 2 Married 2 No 72 hours after 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 □ Divorced 'natural", Specify: White Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Glass Packaging Institute College (1-4 or 5+) 5+ Elementary/Seconday (0-12) the Executive Vice President is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ပ Louise Bentz John Spath Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Barbara Peterson/Daughter 921 Dolphin Dr. Malverne, PA 19355 item 27 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ± 6 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 04/09/201 2 Carlisle, PA Department of Important: If any injury or once, Ashland Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ewing Brothers, Funeral Home 630 S. Hanover St. Carlisle, PA 17013 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ tailure respirator disease or condition resulting in death) Medical Due to for as a consequence of) Examiner tion phenmonia Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by chronic Kidney DISENSE 1 Tes 2 No 3 Probably 4 Unknown Vasular disease peripheral 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has diabetes page performed? Yes 2 N 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, f Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Matural 5 Pending injury Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check occurred at the time, date and place, and due to the cause(s) and manner as state 29b. Signature and title of certifie 29c. License number DOD6 4502 Z erson who completed cause of death (Item 23a) (Type, Print) Medical center Drive, pollcille, Mayland 20850 8+1VA Carrenter, MD 9901

State Registrar

CARROLL

NHOD

32. istrar's Signature

2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>012</u> April Physician/ Mary Cleo Dixon 2:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Vantage House Columbia Howard 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 464-22-4239 1 M 2 X F 87 11/10/1924 Texas Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Examiner must be notified at 1 🗌 Yes 2 🔀 No MD Howard Columbia 10e. Street and Numbe 10g. Citizen of What Country? Funeral items 23a 5400 Vantage Point Road Apt. 21044 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 9 þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify. "natural", Completed Specify: 3 X Widowed 4 □ Divorced Year or Dates White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Nurse Nursing traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Cleo Frederick Louise Delafosse Department of Health and Important: If item 27 is m any injury or other traumsonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kurt Schroeder - Son 4097 Howard Drive Niceville, FL 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 04/03/2012 Ardent Crematory 4 Donation 5 Other (Specify) Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Thene Collins 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 1 Nasubar disease or condition Cars Medical resulting in death) Due to (or as a consequence of): Examiner pertension car Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Month Pregnant at time of death Year n signed by the at Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 10 No ျင 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural work?
1 Yes 5 Pending 2 🗌 No ☐ Accident Investigation 6 Could not be within 24 hours after death To the Funeral Director: 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 💢 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

State

atherine

APR 0 4

Columbia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Peyton Marie 1100 ам Dossen 04/01/2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Md Hospital Clinton Prince Georges Social Security Number None Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Hours 2 Min 19 **Director** 1 🗆 M 2 🗶 F Maryland Usual Residence of Dec 28a-f show 0a. St. 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Completed by Funeral Director Charles Waldorf 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 4582 Grebe Place **23**a 20603 U.S.A. L 1215-0036

Lead to the should be filed within 72 hours after death. Department of Health and Mental Hygiene. Important: If item 27 is marked others any injury or others. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. 1 XXNever Married 2 Married 1 Yes 2XXNo **Black** 1 Yes XX No Specify. Specify. 3 Widowed 4 Divorced Year or Dates Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) N/A Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle Last)
Hilary Dossen 18. Mother's Name (First, Middle, Maiden Surname)
Darnita Smith ပ္ 19a. Informant's Name/Relationship (Type, Print)
Darnita Smith (Mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4582 Grebe Pl Waldorf Md 20603 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) |Fort^{me}tricoln*ercle*sery: 04/09/2012 Brentwood Md 22 Name and Address of FacilityLee Funeral 6633 Old Alexandria Ferry uneral Service ¹Rd Clinton Md 20735 04 MD 23a. Part 1. Enter the dis shock, or hear failu Immediate Cause (Final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line. Approximate Interval Between 22 Onset and Death Physician/ revalle disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Unidenying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): as the burial-trar Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

December 4 time of death 5 Other (specify) nse 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?
1 Yes 2 No Month Day Year detached 9 Unknown g Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? this certificate 1 ☐ Yes 2 ☐ No Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: Mann of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After t 28d. Describe how injury occurred 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident Investigation after death Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) __ Homicide determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier C Highing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge. Joseph occurred at the time, date and place. only or Signature and litle of certifier 29d. Date signed (Month, Day, Year) Wa

Registrar
DHMH 17 Rev 06-2011

of person who completed cause of death (Item 23a) (Type, Print)

7503

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 28, 2012 Year Lavaughn Pearl Dickinson Physician/ 10:21 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Carroll Hospital Center 9. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Days Hours Oct 31. 1940 Maryland 71 220-40-9204 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b County 10c. City, Town or Location death with the Maryland Director Taneytown 1 Yes 2 No Examiner must be notified Carroll Maryland 10g, Citizen of What Country? 10f. Zip Code 5 10e Street and Numbe 21787 Funeral USA "natural", or items 23a 1808 Otterdale Mill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No Black White etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Medical Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Pearl Hess 2 Herman West 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 1808 Otterdale Mill Road, Taneytown, MD 21787 William J. Dickinson, husband 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4/2/2012 Taneytown, MD Mt Pleasant Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 ure of Funeral Service Licenses 21. Sign Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death MYOCARDIAL INFARCTION Immediate Cause (Final Physician/ MINUTES disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner YEARS Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury DIABETES MELLITUS To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and as been signed by the attending physician and 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? page 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical completed filled in by the funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 Inpatient 2 KER/Outpatient 3 I DOA မ 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Manner of Death Certificate: 1. Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MARCH 29, 20/2 -0014367 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21787 MD -INTRICUM, M.D ONE KINGS DRIVE TANGYTOWN WILLIAM

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month

APR

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 20 | 2 State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2. 1:00 P Mary DeMarr Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Charles 10955 DeMarr Road White Plains If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days Months Hours Min 214-28-3846
Usual Residence of Decede **Director** 1 - M 2 X F 83 July 25, 1928 Maryland 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified XX Yes 2 No Maryland Charles White Plains ö 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n Funeral 10955 DeMarr Road 20695 items filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. the Medical Examiner Black, White, etc. 1 Never Married 2 Married ō ģ ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X☐ No Specify. White "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Federal Government Elementary/Secondary (0-12) College (1-4 or 5+) 12th. Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Philip Warren Richards Hazel Berry Willett other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 8865 Port Tobacco Road, LaPlata, MD. 20646 <u> Alice Olmsted/ Sister</u> Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Trinity Mem. Gardens April 7, 2012 Waldorf, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Huntt Funeral Home MOII BO35 Old Washington Rd. Waldorf, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mod of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ X disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of nding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy To the Hospital or Attending Physician; The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter Dav Month Year Pregnant at time of death signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe Yes 2 X No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending Accident Investigation filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or iny estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, deat courred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatur And title of certifie 29d. Date signed who completed cause of death (Item) 31. Date filed (Mo Registrar's Signatur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 04/01 / 2012 Year Physician/ Hilary Avden Dossen 0748 Ам Medical 4a. Facility Name (if not institution, give street and number)
Southern Md Hospita1 4c. County of Death Prince Georges 4b. City, Town, or Location of Death Clinton **Examiner** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 4^{Mir} none 0490172012 **Director** 1 **X X**M 2 \square F Maryland 10c. City, Town or Location Waldorf or 28a-f show Coun 10d. Inside City Limits Director Charles MD must be notified 1 Yes 2 No 10f. Zip Code 20603 10e. Street and Nu 10g. Citizen of What Country? 4582 Grebe Place items 23a within 72 hours after death with 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ "natural", or 1 X Never Married 2 Married ☐ Yes 2**XX**No Yes, Give Black 1 Yes 2XXNo Specify: Specify 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life DO NOT useretired)
NONE N/A 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1 any injury or other traumatic event. He Man N/A None Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Hilary Dossen Darnita Smith 19a. Informant's Name/Relationship (Type, Print)
Darnita Smith (Mother) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4582 Grebe Pl Waldorf Md 20603 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 04/09/2012 Brentwood Md 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Lee Funeral Home 6633 Old Alexandria Ferry Rd Clinton Md 20735 MD 965 Part 1. Ergo the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner re mature Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed the burial-transit Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Month Day Year be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 certificate 2 No or Attending Physician: funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 2 No Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 29a. Certifier YCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar
DHMH 17 Rev 06-2011

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

SURPATTS ROAD, CLINTON MD

-Naber

Registrar's Signature

Day, Year)

APR 0 5 2012

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	aryland / Depa			lental Hygi	ene g. No. 201	2 12116
			Registrar 1. Decedent's Name (First, Midd)	le. Last)	Cer	tificate of E	<i>Jeain</i>	Re 2. Date of Death		3. Time of Death
п	Physicia Medic		Lucy		Dudley			Month April		ear
4000	Examin		4a. Facility Name (if not institution			4b. City, Town, or	Location of Death		4c. County of	Death
nerel d			48540 Mattap 5. Social Security Number		je (In yrs. last birthday)		gton Park	8. Date of Birth		Mary s Birthplace (State or Foreign
Sil	Funeral Director		219-12-3020	1 M 2 X F	92 Yrs.	Months Days	Hours Min.	(Month, Day, \	/ear)	Country)
	d t t		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Loc	nation .		03/03/1	920	Maryland 10d. Inside City Limits
	arylan a-f sh fied a	Director		·						1 Yes 2 X No
	or 28		Maryland St 10e. Street and Number	. Mary's	Lexing	ton Park		10	g. Citizen of Wha	•
	h with	Funeral	48540 Matta			206			USA	\
(0	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Ma	12. Was Decedent Armed Forces?	. If	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
0036	urs afte ural", I Exan	ted b	3 X Widowed 4 ☐ Divorce	If Van Give	1	Yes 2 K No	Specify:		Specify:	Black
15-(72 hou n "nati ledica	Completed		ent's Education nest grade completed)	(Give k	ent's Usual Occupa kind of work done d O NOT use retired)	ation during most of work	ing 1	6b. Kind of Busir	ness/Industry
212	within giene. er thar the N		Elementary/Secondary (0-12)	College (1-4 or	5+) IIIe. DC	Custodi	an		School	l Board
Maryland 21215-0036	e filed tal Hyg ed oth event,	To Be	17. Father's Name (First, Middle,				18. Mother's Nam	e (First, Middle, Ma	aiden Surname) SON	
ıryla	ould be id Men marke matic	-	Douglas 19a. Informant's Name/Relation	Carrol1	10h Mailin	a Address (Street s	and Number or Rura			e. Zin Codel
Ma	d 2 sho alth an 27 is or trau		James E. Carr				r Dr., Le			
Baltimore,	of Her of Her If item		20a. Method of Disposition 1 Burial 2 □ Cremation	3 Removal from State	20b. Place of Dispos	sition (Name of natory or other plac		Date 2	0c. Location - Ci	ty or Town, State
ţim	t. Page tment rtant: njury o		4 Donation 5 Other	(Specify)	St. James					n Park, MD
Bal	permi Depar Impo any ir		21. Signature of Funeral Service	Hardin	ver) 2	Name and Address Mattingle 41590 Fer	ss of Facility Ey-Gardin wick St.	er Funera , Leonard	al Home, Itown, M	P.A. D 20650
ı				or complications that cause only one cause on each lin	d the death. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
<u></u>	Medical		Immediate Cause (Final disease or condition resulting in death)	aa	a consequence of):					Onset and Death
	Examiner			Due to (or as	CAD					
-	n ti	niner	Sequentially list conditions, if any, leading to immediate cause. Elter chooling	Due to (or as	a cons, quence of):	and	Lr-	18		
	ecuter and Il-trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):	ary	7 (
09	death certificate be executed the attending physician and ed for use as the burial-transit	dical		d		U				
876	tificate ng phy e as th	Med	IF FEMALE:						1	
Box 687	eath certifical attending ph d for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live Birth 4 Pregnant	2 Fetal death 3	Ectopic pregnanc	су		23d. Date of Month	
. B	the dea by the a	hysi	1 U Yes 2 No 9 Unknown	9 Unknown	at time of death 5 E					
ls, P.O.	The law requires that the death ate has been signed by the atterpage 2 should be detached for	þ	Part II. Other significant condit	ions contributing to death I	but not resulting in the u	nderlying cause giv	ven in Part I.			ute to the cause of death?
Division of Vital Records,	s law require has been sig ge 2 should l	Completed						24a. Was an autopsy	pric	re autopsy findings available or to completion of cause of
Re	: The la cate ha r, page							perform 1 🗆 Yes 2		ıth? ☐ Yes 2 ☐ No
/ital	ysician: The is certificate director, pag	To Be	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital:	ient 2 C ER/Outpatien	Othe	er:	me 5 Resider	oce 6 Other (Specify)
of \	₽ = E		27. Manner of Death 1 Natural 5 □ Pend	28a. Date of inju	ury 28b. Time of	28c. Injury work	y at	28d. Describe hov		Specify
ion	ttendir death. tor: Af	Certificate:		tigation		M 1 🗆	Yes 2 No	00(1 1: (0)		D. of D. to M. makes
ivis	l or At after Direc d in by		4 Homicide deter	mined 28e. Place of Inj building, et	ury - At home, farm, stre c. (Specify)	eet, factory, office		City or Town,		or Rural Route Number,
ш	To the Hospital or Attending Physician: whithin 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifyir (Check 2 Medical	ng Physician: To the best of Examiner: On the basis of	f my knowledge, death o	occurred at the time	e, date and place, a on, death occurred a	nd due to the caus t the time, date and	e(s) and manner place, and due to	as stated. the cause(s) and manner stated.
	To the Northin 2 To the Football	Me		ng Nurse Practitioner: To the			he time, date and pl	ace, and due to the		ner as stated.
	H S H Ö		1 755	nah			47066		4.9.	
	- nt ()		30. Name and address of person			Print)			20650	
5)	RIME Stat	10	Avani D. Sha		2650 Cedar		Leonard	LOWII, MD	20030	
	Registra	ar	31. Date filed (Month, Day, Year)	1 2012	rar's Signature	racke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Springfiel Drennan 11:40 Beatrice A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgome National Home Rackville Social Security Number 9. Birthplace 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth State or Foreign **Funeral** 1 □ M 2 🔀 F Days Hours Min. (Month, Day, Yea Country) 579-24-7199 PA 86 **Director** 1-5-1925 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Purcellvilla 1 XYes 2 No VA Loudour 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20132 37830 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Jecreto Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Spring Field Martha John Maurice injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 is any injury or other trau Purcellville, VA Martha W. Midolo - Daughte <u> 37830</u> Reminator 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Drexell Hills, 4 ☐ Donation 5 ☐ Other (Specify) Arlington 22. Name and Addres of Facility 21. Signature of Funeral Service Licensee 896 Purallville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on a chiline. such as cardiac or respiratory arrest, Approximate Interval Betweer Immediate Cause (Final Onset and Death Ph. sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the dea h certificate be executed been signed by the a tending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? SUM within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

APR

Charles W. Karesh, MD 26033 Ridge Road, Damascus, MD 20872

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene for State Registrar 12118 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ April 2012 5:53 PM William Jacob Elperin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda Social Security Number If Under If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min Month: Director 270-10-2445 1 **X** M 2 □ F 94 March 23, 1918 Detroit, MI Usual Residence of Decedent 28a-f show notified at 10a. State 10c. City. Town or Location Director Florida Charlotte Port Charlotte 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 1489 Kensington Street 33952 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ed Forces? Yes 2 No Armed Fo Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Caucasian If Yes, Give Year or Dates. 1942-45 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Engineering Electrical Engineering and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Rose Bernstein Morris Elperin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11101 Hunt Club Drive, Potomac, Maryland 20854 Phyllis D. Elperin, Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory 4/5/2012 Brentwood. Maryland 4 Donation 5 Other (Specify) M01102 22. Name and Address of Facility Simple Tribute Funeral Service Ligensee 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Arterio Schlorotic Cardiovascualr Disease unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) burialnding physician use as the burial Physician/Medical use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an is certificate has to director, page 2 s this certificate 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be 1 🗆 Yes 2 🗶 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) ဂ္ဂ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Prwithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funera 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work?
1 Pes 2 No Accident
Suicide Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D31027 April 2, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5+ 8600 Old Georgetown Road, Bethesda, Maryland 20814 P. O'Brien. State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

11/2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Barbara Jean EMRICK 710 P M Apri Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Meritus Medical Center Hagerstown If Under 24 Hrs. Hours Min. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 217-73-1825 **Director** 1 🗆 M 2 😾 F 67 Vrs Aug. 5, 1944 Maryland Usual Residence of Decedent 28a-f show at 10a. State 10c. City. Town or Location Director notified 1 X Yes 2 No Washington Hagerstown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 21740 USA 803 Salem Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11 Marital Status er than "natural", or iter the Medical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white Specify: Completed 3 X Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) elementary school should be filed within and Mental Hygiene lunch aid Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, 2 Esther Mills Russel Whitaker other traumatic age 1 and 2 should be not of Health and Mer t: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 803 Salem Avenue, Hagerstown, Md. 21740 Tina Burkett Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date injury or 1 Burial 2 X Cremation 3 Removal from State Department Important: I any injury or Hagerstown, Maryland 4/6/12 Hagerstown Crematory 4 ☐ Donation 5 ☐ Other (Specify) MINNICH FUNERAL HOME Funeral Service 22. Name and Address of Facility 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 the as 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death 9 Unknown the P.O. signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an ate has page 2 s autopsy perform Yes 2 certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 DX6 ပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Mann Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation completely filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical l 💪 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,

Registrar

State

30. Name and address of person who completed cause of death

artone

M

Pensylvana

(Item 23a) (Type, Print)

3424

Registrar's Signat

50362

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William 1:44 p.mM. Joseph Elder 2012 Medical <u>April</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14718 MacArthur Drive <u>Scotland</u> Mary's Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 220-82-5459 Director 1 X M 2 - F 47 11/1/1964 Washington, D.C. Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No Maryland St. Mary's Scotland 10e. Street and Numbe ms 23a or must be r 10g. Citizen of What Country? Funeral 14718 MacArthur Drive 20687 United States items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. "natural" Completed Specify: White 3 Widowed 4X Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Ceiling Specialist Construction Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lee James Elder Patricia Helen Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Elder / Daughter 16176 Murphy Place, Hughesville, MD 20637 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Brinsfield Echols Cre 4/11/2012 4 ☐ Donation 5 ☐ Other (Specify) Charlotte Hall. MD Simulation of the Service Service Edward N. Brinsf: 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield, Jr. MO0052 22955 Hollywood Road, Leonardtown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 Yes 2 No 3 Probably 4 Unknown been signature Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 2 🗌 No 1 Yes **Division of Vital** • Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifical filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 XN0 ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 [To the within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1005575 30. Name and address erson who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

Schmidt,

APR 10

D.0

32. Registrar's Signature

Jennifer

40900 Merchants Lane.

Suite 205, Leonardtown,

20650

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	of Maryland / Dep			lental Hygier	ne 2012	12121
			Registrar 1. Decedent's Name (First, Middle, Last)	Ce	ertificate of De	eatn	Reg.	No. 2012	
	Physicia		John Ignatius	Evans			Month	Day Year 2012	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and n		4b. City, Town, or L	ocation of Death		4c. County of Death	
			Chesapeake Shores Nurs		Lexingto			St. Mar	
Š	Funeral Director		5. Social Security Number 218-24-6608 Usual Residence of Decedent	7. Age (In yrs. last birthday) 83 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea) 07/10/19	r) Cour	place (State or Foreign http:/ yland
	and show Lat	Į.	10a. State 10b. County	10c. City, Town or L	ocation			<u> </u>	10d. Inside City Limits
	Maryll 28a-f otifiec	Director	Maryland St. Mary's		Lexington 1	Park			1 🗆 Yes 2 😾 No
	h the Baor		10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	ntry?
	ath wir	Funeral	20033 Point Lookout Ro		. Was Decedent of Hisp		raify Von or No-	United St	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	b	Armed	Forces? es 2 X No Give	If Yes, specify Cuban,	Mexican, Puerto	Rican, etc.)	Black, White,	etc.
15-0	72 hou "natu edica	Completed	15. Decedent's Education (Specify only highest grade complete	ed) (Give	edent's Usual Occupat e kind of work done du		ng 16b	. Kind of Business/Ir	idustry
712	vithin interestrated within it is that it is interestrated in it is interestrated in its inte		Elementary/Secondary (0-12) College	(1-4 or 5+)	DO NOT use retired) eman		Sta	ate Highwa	av Admin.
pu	filed v al Hyg d othe	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Maide		, 1144
yla	should be file n and Mental b 7 is marked o raumatic eve	၉	Arthur Evans			Mary	Bowles		
Mar	shou hand 7 is m traum		19a. Informant's Name/Relationship (Type, Print)	1	iling Address (Street an				
ė,	and 2 Healt tem 2		Mary Jean Evans / Spou	20b. Place of Disp	33 Point Lo			ton Park. Location - City or T	
Jour	ent of ent of nt: If ii		1 X Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	om State cemetery, cre	ematory or other place)			,	,
Baltimore, Maryland	permit. P Departm Importar any injur		21. Signature of Funeral Service License		e Cemetery 22. Name and Address	of Facility Bri	<u>1/2012 Gr</u> nsfield Fi	neral Ho	ne
<u>m</u>	8 8 E 8 8		Danielle Ward M01403		22955 Holl				
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Divisio	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	l Certificate:	3 Suicide 6 Could not be 28e. Pla	ce of Injury - At home, farm, st Iding, etc. (Specify)	treet, factory, office		28f. Location (Street City or Town, Sta		l Route Number,
	To the Hospi within 24 hou To the Funer completely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the only one) 3 Certifying Nurse Practition	pasis of examination and/or inve	estigation, in my opinion, e, death occurred at the	, death occurred at time, date and pla	the time, date and pla	ice, and due to the ca	ause(s) and manner stated.
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Registrar DHMH 17 Rev 7/2009

State

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Division of Vital

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death For State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D**2**012 Physician/ March 28. 11:41 PM Elaine Clare Fleishell Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 13240 Old Chapel Road Prince George's Bowie Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Min. Director 579-36-7074 1 🗆 M 2 💢 F 1930 Pennsylvania Sep. 12, 81 Usual Residence of Decedent show 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director 1 X Yes 2 No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20720 USA 13240 Old Chapel Road ral", or items ? Examiner mus death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Armed Force Completed by Black, White, etc. 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural", 3 Widowed 4 X Divorced Specify: White Year or Dates event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas J. McDonough Bertha V. Imhoff injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a Elaine Fleishell/ Daughter 13240 Old Chapel Road Bowie, MD 20720 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Department of P Important: If ite any injury or ot once. 1 XI Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Lincoln Cemetery 4/2/2012 Brentwood, MD 21. Signature of Funera S 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, shock, or heart failure. List o complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician mers disease or condition Medical resulting in death) Examiner Cardio Vascular Di Sease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (or as a consequence of requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 the attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy performed? Yes 2 No Hospital or Attending Physician: The 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Tyes Other: ဂ္ 1 Inpatient 2 Impatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpa 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Tol 29d. Date signed (Month, Day, Year) 20108 OK 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakesh Arora, M.D. 14300 Gallant Fox Road Suite 222 Bowie, MD 20715

State Registrar 31. Date filed (Month, Day, Year)

APR 0 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Ma	aryland / I	•	artment of H tificate of D		i Mental I	Hygien Reg. N	2 0	12	12121	ł
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and P			Montgomery Hospice 5. Social Security Number 6. Se		House (In yrs. last birt	thdav)	Derwoo If Under 1 Year	d If Under 24 H	Irs. 8. Date o	f Birth	Mont	gomen	ace (State or Foreign	,
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and be filed	ked off	To Be	17. Father's Name (<i>First, Middl</i> e, <i>Last</i>) Jeremiah Francis	Fahy					Name (First, Mic abeth T					
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after	n and wetter trygene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (T	ype, Print)	198	o. Mailir	ng Address (Street a Brooke Me	nd Number or	Rural Route Nu	mber, City	or Town, S	tate, Zip C	ode)	Ų
and 2	tem 27		Susan F. Little /	Daughter	20b. Place o	of Dispo	sition (Name of		Date	20c.	Location -		wn, State	-
Page 1	ant: If i		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific				eaven Cem	etery	April 1 2012	O, Si	llver	Spri	ng, MD	
Balt permit.	Department of health and mental Important; if item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Leens	see		F 5	Name and Addres rancis J. 00 Univer	soffacily sity B	ns Fune lvd., W	ral H	Home, Llver	Inc. Spri	ng, MD 209	90
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lot			30. Name and address of person who	completed cause of d	eath (Item 23a)	(Type, I	Print)		1 MD 2	0855	-	11		
(01	Sta	te	Debrah Miller, CF 31. Date filed (Month, Day Year)	32. Registra	uncaste ar's Signature			Derwood	ı, MD Z					_
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 29d per dr., g927, U5/02/2012dhb
Certificate of Death
Reg. No. 1 - For State Registrar 12125 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 11:05 PM 2012 Elmer Harry Ferguson, Medical 4c. County of Death City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4b. **Examiner** tizen Norsing If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth e (In yrs. last birthday, **Funeral** Country) Maryland 1 🕅 M 2 🗆 F Min Months Days Hours (Month 88 **Director** 218-26-0203 1923 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland notified at Director Maryland Harford Havre de Grace 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? United States of 10e, Street and Number permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. Funeral 313 Darlington Road 21078 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 - Widowed 4 - Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Administrator Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Elmer Harry Feruson, Sr. Virgie Sampson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zio Code) Shirley Marsh (daughter) 313 Darlington Road Maryland 21078 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Deer Creek Harmony 04/12/2012 Darlington, Maryland 22. Name and Address of Facility Zellman Funeral home, P.A 123 S. Washington St. Havre de Grace, MD 23a. Part 1. Enter the distance, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail. e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dementin Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the bunial-tran that initiated events resulting in death) Last Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year cate has been signed by the atterpage 2 should be detached for Day Pregnant at time of death 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 ☐ Yes 2 🗷 25. Was case referred to medical examiner? Division of Vital Hospital or Attending Physician: 26. Place of Death (Check only one) funeral director, Be Hospital Other: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 IDOA ပ Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Investigation Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

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30. Name and address of person who completed cause of death (Item 23a) (Type

-erguson

Um.

J. Broke

(WI)

32. Registrar's Signature

April 30, 2012

21078

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1853 Griffin arter 31,2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UMMC Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. **Director** 234-38-8872 1 X M 2 🗆 F 82 12-19-1929 N.C. Usual Residence of Decedent 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Ridgely 1 Tes 2 No Caroline Md ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 23877 Holsinger Lane 21660 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ö þ 1 Never Married 2 Married Maryland 21215-0036 nan "natural", e Medical Exan 1 ☐ Yes 2 K No Specify: 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+ the 2 should be filed with h and Mental Hygien 7 is marked other to Line Worker Poultry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hazel Griffin Stokley other traumatic Roscoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Hazel Dunn / Daughter P.O.Box 54, Ridgely, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 04 - 07 - 12Hillsboro, Md. Sandtown Cem 22. Name and Address of Facility 426 Dover St Easton, Md. 216 21. Signature of Funeral Service Licenses .2160 Bennie Smith Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Biliary Ph, sician/ peritonitis disease or condition Medical resulting in death) Due to (or as a conseque ce of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Exami The law requires that the death certificate be executed and -trar Due to (or as a consequence of): resulting in death) Last burial physician Physician/Medical Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year 2 No 9 Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? After this certificate 1 Yes 2 No Yes To the Hospital or Attending Physician:] within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to redical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Yes ᅆ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical rtifyi g Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
edi. • I Examiner: Cn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Cermying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and certifie AU4176435 MLOO777 G. HAKFAR MD March 31,2012 315 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G: Hak Far 22 5 Greene 5 54. Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

APR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ L. HINES Month 03 AUL 12:10 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CENTER CRESCENT CITIES Prince George's Riverdale 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 226-40-9969 Hours Months 08/26/193 **Director** V<u>irginia</u> Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XXIO Maryland Prince George's Ft. Washington 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7709 Bock Road 20744 USA death 11. Marital Status . Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian or i Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 X Married 72 hours after Yes 2 X No Maryland 21215-0036 1 Yes 2 K No Specify: If Yes, Give "natural", Black Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher years Education other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isaiah Hill Hines Lottie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Jacqueline Hines / Wife 7709 Bock Road Ft. Washington, Maryland 20744 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 04/03/2012 Kalas Crematory 4 Donation 5 Other (Specify) Edgewater, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facilit George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ CONGESTIVE HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exami and that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical that the death certificate be Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No g 🗌 Unknown g Unknown P.O. ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No Yes 2 director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After a completed filled in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) eser D0067761 03 31

State Registrar

DHMH 17 Rev 7/2009

Lane, Largo, MD

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Desai MD,

ÄPŘ 03 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012ar April 1. Eldon William Hall 1043 A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth Davs Hours (Month, Day, Year) 296-14-0319 1 X M 2 | F Yrs. 92 12/29/1919 Usual Residence of Deceder OH 10c. City, Town or Location 10d. Inside City Limits Frederick 1 Yes 2 X No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5820 Genesis Lane #526 21703 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 🔀 Married 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: Year or Dates Whi<u>te</u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Mechanical Engineer engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Hall Anna Fruth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5820 Genesis Lane, #526, Frederick, Hildegard Hall/wife MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Gabriel Cemetery 04/04/2012 | Potomac, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityStauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death disease or condition resulting in death) 150166 as a consequence of umonie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Pregnant at time of death Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician Medical Examiner

physician

signed by

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n 24 hours after death.

e Funeral Director: Af bletely filled in by the fu

within 2

that the death certificate be executed

Box 68760

P.O. |

Division of Vital Records,

Hospital or Attending Physician:

death.

Physician/

Medical

10a. State

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Examiner

Funeral

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Department of Health an Important: If item 27 is any injury or other trau

within 72 hours after

Maryland 21215-0036

Baltimore, 1

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Funeral

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as attending plant of the season been signated by should be

Exami Physician/Medical by Completed 25. Was case referred to medical Be ဂ္ 27. Manner of Death Certificate:

examiner?

1 Natural

Accident

Suicide

4 Homicide

29a. Certifier

JE FEMALE 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

1 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Investigation

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 Yes 2 🗆 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

24a. Was an

autopsy performed Yes 2 No

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier

2 1 No

5 Pending

6 Could not be

determined

All In D6041 29d. Date signed (Month, Day, Year,

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Whican Dr 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar 19a, FH, 3/30/12, rls Amended.# Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ CLIFFORD L. HILK MARCH 28 1:50P . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death WILLIAM HILL MANOR EASTON TALBOT Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Min. Hours 11 14 1 1937 Director 181-28-2855 74 PENNSYLVANIA Usual Residence of Decedent shov 10a, State 10b County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 □ No TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be Funeral 23a must 29177 PIN OAK WAY 21601 USA death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Examiner Black, White, etc. ò þ 1 Never Married 2 Married 1 ∑ Yes 2 □ No If Yes, Give 1956–1958 Year or Dates. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 X Widowed 4 Divorced WHITE Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 EXECUTIVE BANKING Be 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked ot r other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) မ DOROTHY E. SCHUBERT VINCENT KENNETH HILK CHERYLE Lane HILL Kehid (DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAN A Cheryl Hilk/Daughter 505 LEONA STREET SHARPSVILLE, PA 16150 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or oth 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State HILLCREST MEMORIAL PARK 04/03/2012 HERMITAGE, PA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee FELLOWS AddHELFENBEIN & NEWNAM FUNERAL HOME 200 SOUTH HARRISON STREET EASTON, MD 21601 JOHN R. MERCER 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{sician/} 110 blastoma mult) forme disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Linter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? for Day Pregnant at time of death Year the detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 3 Probably 4 Unknown 1 Yes 2 No been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy Hypertens12 this certificate Yes 2 or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient '2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After Natural Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 To the I within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

RS 12+1 VA State Registrar 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MA

29d, Date signed (Month, Dav. Year)

MI

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First Middle 1 ast) 2. Date of Death 3. Time of Death Physician/ 5:05 pm 2012 Geraldine Hubbard March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bel Pre Health & Rehab Center Silver Spring Montgomery 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Hours **Director** 231-18-6519 1 🗆 M 2 🎗 F 11/30/1920 91 Virginia 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Tes 2 X No Maryland Montgomery Silver Spring 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 13 Ashmont Court 20906 U.S.A. or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces?
1 Yes 2 No þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: Hygiene. other than "natural", If Yes, Give 3 - Widowed 4 Divorced Black Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Assembly Technician Auto Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ည Louis Sheldon Alice Logan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau 13 Ashmont Court, Silver Spring, Maryland 20906 Carole McAlpine - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Lincoln Crematory: 04/09/2012 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Lipenson 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph sician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami law requires that the death certificate be executed that initiated events and-trar Due to (or as a consequence of) resulting in death) Last buria attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 K No the 9 Unknown 9 Unknown Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Obstructive Pulmonary Disease 1 Yes 2 No 3 X Probably 4 Unknown Cerebrovascular Accident 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? has page After this certificate 2 🗆 No 2 **X** No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 X No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Director: / 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Funeral [🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D53411 April 04. 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

Jagdish Shesadri,

M.D.,

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14300 Gallant Fox Lane, #210, Bowie, Maryland 20715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 4/6/2012 per FH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jackie Welford Harich Jr. Physician/ 10: 00^AM 04/03/2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore cial Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 215-72-9882 Days Hours Director 1 X M 2 🗆 F 53 05/25/1858 D.C. 28a-f shov 10a. State 10c. City, Town or Location Director 10d. Inside City Limits must be notified Anne Arundel Jessup MD 1 Yes 2XXIo 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 7810 Clark Road Lot A15 20794 United States items ; 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examinone. Black, White, etc. 1 Never Married 2 X Married Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Tes 2 X No Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Automotive Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Catherine Juanita Rickman Jack Welford Harich Sr. 19a. Informant's Name/Relationship (Type, Print)

Karen M. Harich/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7810 Clark Rd. Lot A15 Jessup, MD 20794 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 3/10/2012 Cumberland, RI 4X Donation 5 ☐ Other (Specify) Med Cure Inc. ^{22. Name and Address of Facility}D Alessandro Funeral Home 4522 Butler St. Pittsburgh, PA 15201 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ amplications disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINES. physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 the as attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 4 ☐ Pregnant : detached 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗆 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) No SOLCE funeral ner of Du 1 Natural 2 Accident 27. M nner of Death 28c. Injury at work?
1 Yes 2 No After t Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending iniury UMK 1992 after death Accident Investigation FALL KROM ROPE SWING 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined RIVER within 24 hours a

To the Funeral C

completely filled filled Severn RIVEZ, MARYLAND Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 58503 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) AALON CHARLES N. Charles ST M 701 31. Date filed (Monti State Registrar

Amend Item 8 WCHD/JW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Maryland State of Maryland State of Maryland Registrar	7,05/6 Cer	artment of H 19/2012dh tificate of L	lealth and l b Death	ا Mental Hy	giene Reg. No. 20	12 121	32
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-	Medic Examin	al	Retha Lee Jones 4a. Facility Name (if not institution, give street and number)		4b City Town o	Location of Death	April	5, 201 4c. County		\mathbf{P}^{M}
may of	Exami	ei	108 Hawkins Drive		Abero	_		1	ford	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las:	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h	Birthplace (State or Fo Country)	oreign
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	yland •f sho ed at	ctor	10a. State 10b. County 10c. City,	Town or Lo	cation				10d. Inside City Li	
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	death items ner m		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Vas Decedent of H	ispanic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Rac	e - American Indian, k, White, etc.	
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Baltimore,	permit. Page Department of Important: If any injury or once.		Signatur of Funeral Service Licenses	22	. Name and Addre	ss of Facility Va	nreene	n Fune:	ral Home	
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	•		30. Name and address of person who completed cause of death (Item 2	23a) (Type, F	Print)	+n 120	Merder	4 - 443	- 0.41	
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29b. Signature and title of pertifier	1/2/1	la n	29c. License	3/46/ ₅	290	1. Date signed (Month	, Day, Year)
30. Name and address of cerson who con LUDWIG J. EGLSED	- /		OD DRIVE	, EASTON,	, MD 216	01	
State Registrar 31. Date filed (Month, Day, Year) APR 4 2012	32. Registrar's Signatur	bar	w				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 201 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear Physician/ April John Henry Kunkleman, Jr. 6:50 PM 2012 Medical Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Meritus Medical Center Hagerstown If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth
Jan. 14,1928 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 216-22-7585 Maryland 1 XM 2 □ F 84 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State must be notified at Director WV Berkelev Falling Waters 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 25419 106 Cassie Dr. U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status the Medical Examiner rmed Forces?
Yes 2 No
Yes, Give Black, White, etc. ö þ 1 ☐ Never Married 2 🏹 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Electrician Railroad Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ortant: If item 27 is marked o injury or other traumatic eve 2 John Henry Kunkleman, Sr. Mae Off Kunkleman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trauonce. Doris E. Kunkleman-wife 106 Cassie Dr. Falling Waters, WV 25419 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Manor Cemetery 4-6-2012 Boonsboro, MD 22, Name and Address of Facility 21. Signature of Funeral Service Licensee Douglas A. Fiery Funeral Home) ceciple. 1331 Eastern Blvd. North Hagerstown. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 L g ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certificate: To Be Completed by 2 No Division of Vital Records, 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 Yes 2 No certificate Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{Alo} \) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Manatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d Describe how injury occurred iniury 5 Pending s after death. 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20063233

State Registrar 580C

Northern Are Hagerstown MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

sod

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Wayne Francis Kamahele April 2100 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 39 Crestwood Drive Ceci1 E1kton Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 - F Days Hours Min. OCT 31. T954 Texas Director 575-62-6965 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shouy or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 39 Crestwood Drive 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1974 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 1 X Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 X Married 2 Baltimore, Maryland 21215-0036 Hawaiin/Pacific 1980 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Completed Year or Dates **Islander** 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Veterans Elementary/Seconday (0-12) College (1-4 or 5+) Veterans Representative Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Kamahele Betty Fong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronda L. Kamahele/Wife 910 Southerly Road, Apt. 458, Towson, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State R. A. Ferris & Co., Inc. West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hicks Home for Funerals, F.A. 21. Signal ure of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Congestiv Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami ig physician and as the burial-transi that initiated events resulting in death) Last Physician/Medical **To the Hospital or Attending Physician:** The law requires that the death certificate be e within 24 hours after death. Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Other (specify) Dav Year Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown by the Unknown signed to Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes certificate has been si rector, page 2 should l Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 KResidence 6 Other (Specify) Hospital: 2 No ೭ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year)

State Registrar John Fill 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of M	laryland / Depa			/lental Hygi	iene		
			Registrar 1. Decetent's Name (First, Min	Idle Last)	Cer	tificate of E	Death	i	eg. No. 20	12	12136
and to	Physicia Medi	cal	JOHN 4a. Facility Name (if not institu	A, LE	OVAN		2	2. Date of Death	7 20	12	3. Time of Death
	Examir	ier		AT BAY RIDGE		ANNAI	Location of Death		ANNE A		DEL
	Funeral Director	Г	5. Social Security Number 155-05-6429 Usual Residence of Deceder	1 🛣 M 2 🗆 F	ge (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 09/26/1	Year)	Birthpla Countr	ace (State or Foreign
	land show dat	호	10a. State 10b. Cou		10c. City, Town or Loc	cation	<u> </u>	l		10	d. Inside City Limits
	Mary 28a-f otifie	Director		E ARUNDEL	A	NNAPOLIS					1 ☐ Yes 2 X No
	/ith the 23a or st be r		10e. Street and Number	EL ON THE BAY	ROAD	10f. Zip Code 21 4	ነበ3	10	0g. Citizen of Wh		,
	tems er mu	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13. V	Vas Decedent of His	spanic Origin? (Spe	ecify Yes or No-	14. Race -		
Maryland 21215-0036	is filed within 72 hours after death with the Maryland tal Hygiene. Id Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ N 3 🛣 Widowed 4 ☐ Divor	16 Van Cive	No 19/1/1-	Yes, specify Cubar		Rican, etc.)		White, et	c.
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pu	be filed vental Hyg ked other ic event,	To Be	17. Father's Name (First, Middl				18. Mother's Name		aiden Surname)		2011
ryla	ld be Men arke	F	JOSEPH LEIDV					BETH REME			
			19a. Informant's Name/Relation		1	g Address (Street a NOMINI D			-	e, Zip Co	de)
Baltimore,	of Healt fitem 2 r other		20a. Method of Disposition		20b. Place of Dispos	sition (Name of	1		21012 20c. Location - C	ty or Tow	n, State
tim	permit. Page Department of Important: If any injury or once,		4 Donation 5 Othe		CHESAPEAKE CENT	CREMATIO	ON 04/03	3/2012 S	TEVENSV	ILLE	, MD
Bal	permit. Page 1 Department of Important: If it any injury or o		21. Sign the of Fune at Service	e Licensee	FF 10	Name and Addres ELLOWS, HI 06 SHAMRO	s of Facility ELFENBEIN CK ROAD.	I & NEWNA CHESTER.	M FUNER MD 216	AL H	OME, P.A.
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	artificat ling ph se as th		IF FEMALE:	00-16	Adh						
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O. E	t the d by the etache	Phys	9 🗌 Unknown	9 🗌 Unknown				T			
Division of Vital Records, P.O.	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	ed by	Part II. Other significant cond	itions contributing to death b	ut not resulting in the ur	iderlying cause give	en in Part I.		acco use contribus 2 \square No 3		cause of death? bly 4 Vunknown
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Divis	To the Hospital or Attending Physician: In the Funeral Director: After this certific completely filled in by the funeral director.			ermined 28e. Place of Inju- building, etc	iry - At home, farm, stre c. (Specify)	et, factory, office		28f. Location (Stre City or Town,		r Rural R	oute Number,
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	2+ ms		30. Name and address of person	on who completed cause of d	eath (Item 23a) (Type	int)	nı	1	N	7 6	21061
(7		31. Date filed (Month, Day, Year	bob 6	458 H	10466	- Blog	OF	y BURG	יפומ	1001
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 1 2 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3. 2012 Physician/ Miriam Reindollar Lane Month March 28, 1:30 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9130 Liberty Village Way Union Bridge Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Y
June 23, 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 😿 F 63 220-50-2012 Director 1948 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Union Bridge Maryland Frederick 1 ☐ Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21791 9130 Liberty Village Way USA items 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 9 Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exa 3 Widowed 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Physical Therapy Physical Therapist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Priscilla Hess Henry Reindollar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21791 9130 Liberty Village Way, Union Bridge, MD 21791 James E. Lane, husband 20a. Method of Disposition 20b. Place of Disposition (Name of Aemeter Demotion Of Place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 3/29/2012 Manchester, MD Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ METASTATIC disease or condition resulting in death) OVARIAN CARCINOUNA Medical Due to (or as a consequence of): Examiner 8 4CARS (2004 Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy ☐ Yes 2 ☐ No 2 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director, After Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

0 State Registrar

only one) 29b, Signature and title of certifier

31. Date filed (Month

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karen Marie Hundemer, MD

aren ware Husland wy

hams Johnson Donne, Suite E

32. Registrar's Signature

29c. License number

D39444

Tredonuck

29d. Date signed (Month, Day, Year)

3129/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Gloria Jean Lawson ADVIL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death REGIONAL HIOMICO Medical 5. Social Security Number 1 Year If Under 24 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Days ^{Year)} 1948 Hours Director 214-56-9732 Arkansas 1 🗆 M 2 💢 63 May Usual Residence of Decedent 28a-f show 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1 Tyes 2 No Accomack Greenbackville o 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2292 Bounty Court 23356 USA "natural", or items Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Drigin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify:White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Manager Industrial Mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked Clinton Amos Remagen Virginia Ellen Hoots 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Robert Lawson/ Husband 2292 Bounty Court, Greenbackville, VA 23356 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) First Bapt. Cem. 4/5/2012 Pocomoke, MD 21851 22. Name and Address of Facility 107 Vine St. Holloway Funeral Home, P.A. Pocomoke, Tack 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph.si.i.n Onset and Death year disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events Examiner Due to (or as a consequence of) burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 LA Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🛣 No Other: 4 Nursing Home 5 Residence 6 Dther (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DDA After this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of or Attending Parties after death. 28c. Injury at work? 28d. Describe how injury occurred 5 Pending (Month, Day, Year) Accident Investigation 1 Yes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral D 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifyin, Nurse Practitioner: To the best of my knowledge duals occurred at the time, date and place and due to the cause(s) and manner at stated. (Check 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

100 & Carroll STEELT Salisbury MD Z1801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. egistrar's Signature

Dr. Fernando ACLE MD

31. Date filed (Month, Day, Year)
APR 0 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For _ State	State of	Maryland				d Mental Hy	2	010	12120
	_		Registrar 1. Decedent's Name (First, Middle,	l ast)		Cer	tificate of E	Jeath	2. Date of De	Reg. No.	UIZ	3. Time of Death
	Physicia Medic		John Edwar	,					April	6 Day 20	12 ^{Year}	10:15 p ^M
	Examin		4a. Facility Name (if not institution,		•		4b. City, Town, or		eath	1	nty of Death	
No.	Funeral		Hospice House 5. Social Security Number		Age (In yrs. las	at birthday)	Callaw If Under 1 Year	ay I If Under 24 I	Hrs. 8. Date of Bi		Mary 9. Birtho	Solace (State or Foreign
333	Director		216-40-9164	1 🕅 M 2 🗆 F	72	Yrs.	Months Days	Hours N	Min. (Month, Da	ay, Year)	Coun	try)
pu	how	۱,	Usual Residence of Decedent 10a. State 10b. County			Town or Loc	cation		July 3	,1939		7 Land Od. Inside City Limits
Aarylar	8a-fs tified	Director	MD St.	Mary's		eonard						1 ☐ Yes 2 🛣 No
the N	a or 2 be no		10e. Street and Number	idly b		conarc	10f. Zip Code			10g. Citizen o	of What Coun	itry?
th wit	ms 23 must	Funeral	22680 Cedar La		99	T ₁₀ v	20650		10		ed Sta	
21215-0036 within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	 11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced 	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Dates	s? X No	l I	vas Decedent of Hi Yes, specify Cuba	n, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)		ace - Americ lack, White, e ify: Whi	etc.
21215-0036 within 72 hours after	'natur dical I	Completed	15. Decedent (Specify only highes	's Education	3.		ent's Usual Occup		working	16b. Kind of	Business/Inc	dustry
121 Thin 72	than '	omi	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. D	O NOT use retired)					
	Hygie other ent, th	Bec	8 17. Father's Name (First, Middle, La	st)		Heavy	' Equipme		cator Name (First, Middle		<u>ructic</u> me)	n
/lan dbe fil	/lental trked tic ev	욘	James Leonard	Latham					le Elizab		,	
Maryland 2 should be filed	n and Mental F is marked o raumatic eve		19a. Informant's Name/Relationshi	p (Type, Print)	1)	19b. Mailin	g Address (Street a	and Number or	Rural Route Numb	er, City or Town	, State, Zip C	(ode)
	Health tem 27 other tra		James Michael La 20a. Method of Disposition	atham/Son	20h Ble		Maddox sition (Name of	Rd. Ch	naptico, l	MD 206 20c. Locatio		yun State
⊼ ⊤	ent of nt: If it y or o		1 Burial 2 □ Cremation : 4 □ Donation 5 □ Other (Sp	Removal from St	ate ce	metery, cren	natory or other place art Cem.		Date . / 1.2 / 2.0 1.2		•	
Baltimore, permit. Page 1 and	Department Important: Il any injury or once.		21. Signature of Funeral Service Lie		10 /1 /ov		. Name and Addres		1/12/2012 Brinsfie			Maryland me. P.A.
m §		Ц	Danielle War	d, M01403	w	22	955 Holl			ardtown		
			23a. Part 1. Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final	omplications that cau ly one cause on each	sed the death. line.	Do not ente	r the mode of dyin	g, such as card	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	y i ian Medical		disease or condition resulting in death)	a. Mul-	as a conseque		loma					Onset and Death
E	xaminer			Due to (or	as a conseque	ince oi).						
T.	÷	inei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a conseque	ence of):						
ecuted	and I-trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to (or	as a conseque	ence of):						
o pe ex	physician and s the burial-transit	dical	,	d								
68760 ertificate b	ng phy as the		IF FEMALE:									
Box death c	been signed by the attending is should be detached for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		th 2 Tetal nt at time of de	death 3 [Ectopic pregnand Other (specify)	у			Date of delive Month	ery Day Year
P.O	ned by e deta	y Pr	Part II. Other significant condition	s contributing to deat	th but not resul	lting in the u	nderlying cause giv	en in Part I.				e cause of death?
ds, quires	en sig ould b	ted							_ 1 🗆	Yes 2 X No	3 🗆 Prot	pably 4 🗆 Unknown
Division of Vital Records, all or Attending Physician: The law requires	ate has page 2	Completed							24a. Was auto perf 1 🔲 Yes		o. Were autor prior to cor death? 1 \(\sum Yes\)	osy findings available mpletion of cause of 2 No
ital ician:	is certific director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗶 No	Hospital:			_ Othe		Check only one)	37	11 11 11	TT
of V	er this ieral di	e: To	27. Manner of Death	28a. Date of		28b. Time of	t 3 🗆 DOA 28c. Injury	4	ng Home 5 Resi	idence 6 🔼 O how injury occu		ноѕрісе
On (eath. or: Afte he fun	ficat	1 XNatural 5 Pending 2 Accident Investiga	ation	Day, Year)	injury	M 1 □	? Yes 2 ☐ No				
IVISI	ours after death. eral Director. After th filled in by the funeral	Certificate:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	28e. Place of	Injury - At hon etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (City or To	Street and Num wn, State)	nber or Rural	Route Number,
L Hospita	4 hours Funeral tely filler	Medical		Physician: To the best aminer: On the basis								ed. use(s) and manner stated.
o the	within 24 ho To the Fune completely f	M	only one) 3 Certifying I	Nurse Practitioner: To	the best of my	/ knowledge,	death occurred at the 29c. License		nd place, and due to	the cause(s) and 29d. Date sign		
P	> ► 0		Sough deb	IM :1	AD.		D71			April	9,2	
			30. Name and address of person w	ho completed cause of	of death (Item 2	23a) (Type, P	rint)		4	. 11	. ,	<u></u>
حنور	Sta	- A	Mran A Junsy 31. Date filed (Month, Day, Year)	32. Regi	100 Mex	chants	lane St	e. 20+	lemaizh	1/1,M1	0 20	620
	Registra		APR 0 9	2012 Am	me ,	a. A.						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ 2012 7:51P Robert Louis Martinez Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Mt Airy Kline Hospice House Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Min (Month, Day, Year) 4/15/1952 NM **Director** 220-60-2775 1 M 2 - F 59 Usual Residence of Deceder 28a-f show 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Frederick Walkersville 10e. Street and Number 10g. Citizen of What Country? Funeral 9414 Daysville Rd. 21793 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ¥ Yes 2 No Specify: Specify: Hispanic 3 Widowed 4 Divorced Completed 1995 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Air Force TSGT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Pauline Purvines Don Luis Martinez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Martinez (Wife) 9414 Daysville Rd., Walkersville, MD 21793 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date . Page 1 1 Burja 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lutheran cemetery 3/31/2012 Middletown, MD 22. Name and Address of Facility
Bonald Briddletown, Funeral Home
POB 18, Briddletown, MD 21769 r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eart failure. List only one cause on each line. Part 1. En Approximate Interval Between hock, or edial use (Final Onset and Death Sarcama Physician/ MEYASTATIC ease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death signed by the all be detached 9 🗖 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed? the Hospital or Attending Physician: The law r thin 24 hours after death. the Funeral Director; After this certificate has b cate has ; page 2 : 2 No 1 Yes within 24 hours after death.

To the Funeral Director; After this certifics completely filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospice examiner? Other: 4 Nursing Home 5 Residence 6 N Other (Specify Hospital: 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one)

Registrar DHMH 17 Rev 06-2011

CX

State

29b. Signature and title of certifier

rash

31. Date filed (Month, Day, Year)

45

6.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Geldstein

501

mD

32. Registrar's Signature

29c. License number

DOG67691

+4 57.

29d. Date signed (Month, Day, Year)

21701

3-30-2012

Frederick MD

12-02507 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Michael Mease 2012 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 2244 hrs March 28, 2012 **Medical Examiner** Michael Ernest Mease 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Montgomery **Bovds** 22211 Shiloh Church Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreign Washington Months Hours Director 218-56-9542 1 M 2 F Yrs Nov.25,1962 49 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b, County 1 Yes 2 No Iltimore, MD 21215-0036

nit. Pages I and 2 should be filed within 72 hours after death with the Maryland partnent of Health and Mental Hygiene.

Sortant: If item 27 is marked other than "antural", or items 23s or 28s-f show ity or other traumatic event, the Medical Examiner must be notified at once. Maryland Gaithersburg Montgomery Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Sunburst Ct 20877 United States 467 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married Yes 1 Yes 2 No specify: Yes, Give Year 3 Widowed 4 Divorced Specify. White á Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Construction 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 8 Norman E. Anna S. Stelock Mease 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Norman E. Mease, Father 22211 Shiloh Church Road, Boyd's, MD 20841 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) 1 Burial 2 Cremation 3 Removal from State Metropolitan
Crematorium, Inc. 03/31/2012 Alexandria, V

22. Name end Address of Facility
Molesworth-Williams, P.A., Funeral Home 4 Donation 5 Other Specify Alexandria, Virginia 21. Signature of Fuperal Service Ligensee 26401 Ridge Road, Damascus, Maryland 20872 Approximate Interval art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death a Coronary Artery Thrombosis Immediate Cause (Final disease Şxaminer or condition resulting in death) Due to (or as a consequence of): b. Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate Due to (or es a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit Division of Vital Records, P.O. Box 68760, tall or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED e attending physician for use as the burial -23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Day this certificate has been signed by the attending in director, page 2 should be detached for use as t Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) B Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes After 28a. Date of Injury (Month, Day,Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 V Natural 1 Yes 2 No Pending within 24 hours after death To the Funeral Director: filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined (Specify) 4 Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 29, 2012 O.C.M.E. Drawl 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001 **OCME 2006**

Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State Criticate of Death Registrar	ia ivientai rij	Reg	No. 201	2 1214			
Physicia	n/	1. Decedent's Name (First, Middle,Last)		Date of Death Month	Day Year	3. Time of Death 1955 hrs			
Medical Examir		John D. Miller	or Location of Death	March 31, 2	2012 4c. County of Deatl				
	П	4a. Facility Name (if not institution, give street and number) 4b. City, Town, of 1056 Eaglewood Road Apt. 2B Annapolis	DI LOCATION OF Death		Anne Arundel				
Funeral	4	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	ear If Under 24Hrs.	. 8. Date of Birth		thplace (State or Foreign			
Director		212-60-2144 XX M 2 F 58 Yrs. Months Da	ys Hours Min.	3/8/19	54	VA			
any	ł	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
* ,	٦	MD Anne Arundel Annapolis	3			1 Yes 2XX No			
ith the Maryland 23a or 28a-f sho notified at once.	Dire	10e. Street and Number 1056 Eaglewood Rd. Apt. 2B 21	1403	10g	, Citizen of What Cou USA	ntry?			
or items 2.	Funeral	1 Yes 2 XX No	an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	White, etc.	ican Indian, Black,			
s after	<u>۾</u>	3 Widowed 4 Divorced If Yes Give Year 1 Yes 2XX N 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occup		vork done	Specify: 16b. Kind of Business	White			
15-0036 filed within 72 hours after death with the Maryland I Hygiene. d other than "natural", or items 23a or 28a-1 she i, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Carpenter Carpenter			Self empi Owner				
5-0(led win	항	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Ma	aiden Surname)				
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica		James Francis Miller		Ann Col		7:: 0::4:			
AD 2 sho 2 sho 27 is mati		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stresharton Falconer: Sister 7810 Clark Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Roman Rom	d. E45 Je	ssup, MD	-				
Baltimore, Normit Pages I and Department of Health Important: If item		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of corematory or other place)			•	,			
timent rtant:	-	4 Donation 5 Other Specify: Atlantic Cremator 21. Signature-of-Funeral Service Licensee, 22. Name and Addre			Glen Burni uneral Hom				
Balti permit Departr Import injury					, MD 21401				
Physician	+	23a. Part I. Enter-the disease, or complications that caused the death. Do not enter the mode of dying	g, such as cardiac o	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and			
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Contact Gunshot Wound of Chest				Death			
Adminici	-	or condition resulting in death) Due to (or as a consequence of):							
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause.							
red 	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			-				
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED	,						
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Vital Recc ysician: The lav his certificate ha director, page 2	Ē			perform 1 Y Yes 2		es 2 No			
tal Rection: The certificate	Bec	T	ice of Death (Check	only one)					
of Vit ing Physic After this c		1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA			Residence 6 🗸 Othe	er: Scene			
C =	Certification:	(Month, Day, Year)	njury at Work? Yes 2 ✓ No	Subject shot	ow injury occurred self				
ivision or Attent after death Director:	흹	3 ✓ Suicide 6 Could not be determined	e building, etc.	or Town, Sta		ural Route Number, City			
lospita hours unera		29a. Certifier 4 Continue The relation To the heat of multipolation death accurred at the time	date and place and						
To the Hospital within 24 hours To the Funeral completely filled	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opini and manner stated.							
To Vivin	Re		nse number		29d. Date signed (M	onth, Day, Year)			
		Carol Hallan 0.0	C.M.E.		April 1, 2012				
	ŀ	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street	et Baltimore M	ID 21223					
ip !	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	or, Daltimore, IV						
Regist		APR 0 3 2012 Leves B. Jacks							

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State Registrar	State of		d / Depa	artment of	f Health	and M	lental Hy		_	12143
Physiciar	n/	Decedent's Name (First, Middle, I LYNN	ast)	MANSE	ATI				2. Date of De Month			3. Time of Death
Medica Examine		4a. Facility Name (if not institution, g	ive street and number			4b. City, Town	. or Location	n of Death	March		UIZ unty of Death	6:10 P ^M
		Kline Hospic					nt Aiı				ederio	
Funeral Director				. Age (In yrs. Ia.		If Under 1 Yes Months Day		er 24 Hrs. Min.	8. Date of Bir (Month, Da		9. Birth Cour	place (State or Foreign ntry)
		201-50-5737 Usual Residence of Decedent	1 □ M 2 💢 F	53	Yrs.				NOV.16	,1958	Penn	sylvania
iryland i-f sho ied at	ctor	10a. State 10b. County Maryland Frede	and ole		, Town or Lo							10d. Inside City Limits 1 Yes 2 □ No
the Ma or 28a e notif	Dire.	Maryland Frede 10e. Street and Number	rick		New Ma	10f. Zip Code	e			10g. Citizen	of What Cou	
s 23a nust b	Funeral Director	143 W. Main St	•			21774				Unite	ed Sta	ites
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artmen ortant: injury		1 ☐ Burial 2 😾 Cremation 3 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Sta		Cremato						Maryland
Dep Dep Imp any		Raymond	Bele	rson		. Name and Add						
be e siciar buri	lical Examiner	shock or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to (or c.		ence of): ence of):	CANC	ER					Interval Between Onset and Death Manney
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2.	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2 🗍 Fetal int at time of de	Ideath 3	Ectopic pregna				23d	. Date of deliv	rery Day Year
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the Hospita nin 24 hours the Funera upletely fille	Medical	(Check 2 Medical Exa	hysician: To the bes aminer: On the basis lurse Practitioner: T	of examination	and/or invest	igation, in my op	inion, death o	occurred at	the time, date a	and place, and	d due to the ca	use(s) and manner stated.
To t To t		29b. Signature and title of certifier				29c. Lice	nse number	/		29d. Date sig	gned (Month,	Day, Year)
		30. Name and address of person wh	no completed cause	of death (Item	23a) (Type. P	rint)	1110	1		04/	02/	2012
3		SADAF TAIM	re 46	13 sui	TE #	D4	HOMA	3 JA	DNSON	De	- F	REDERICK
State Registra		31. Date filed (Month, Day, Year) APR 0 3	2012 32. Re	istrar's Signatu	A. A.	barrel						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07 1145 PM 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 407 LIN COLN DENFON CAROLINE If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 TF Months Hours (Month, Day -03-4 Director Usual Residence of Deceden 28a-f shov 10a. State 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Completed by Funeral Director 1-1 Yes 2 □ No 10 101 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? must be 23a iral", or items 2 Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2- No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify If Yes, Give Year or Dates 3-Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) ome mak Be Father's Name (First, Middle, 18. Mother's Name (First, Midgle, Maiden, ပ္ Urrac Rora PNIL ar 19a. Informant's Name/Relationship (Type, 1 Mailing Address (Street and Number o ral Route Number, City or Town, State, Zip Code) ridge 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place Burial 2 Ocemation 3 Removal fr m State 4 Donation 5 Other (Specify) 07 MD emetery Tilghman 22. Name and Address of Ficility Bolden ston 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ PNEUMONI disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CHRONIC Sequentially list conditions Examine If any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of physician and the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be used to hours after death. Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death ed by the a 9 Unknown Unknown n signed by tail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has leampleted filled in by the funeral director, page 2 s autopsy 2 🗆 No Yes 2 N 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 **N**No မြ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Medical Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) 29a. Certifier Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature ap

Registrar

DHMH 17 Rev 7/2009

State

JAMES

31. Date filed (Month, Day, Year)

609

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00057509

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 55 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WILLIAM HILL GARDENS TALBOT EASTON Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours Min Days 01/09/1937 **Director** MARYLAND 212-36-8589 1 X M 2 - F 75 Usual Residence of Decede 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 X No TALBOT EASTON 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 28168 OAKLANDS ROAD 21601 USA items death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Completed by Black, White, etc 1 Never Married 2 Married "natural", or Page 1 and 2 should be filed within 72 hours after 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: WHITE 3 XWidowed 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. PETROLEUM OWNER & OPERATOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CALVIN MILLER CATHERINE MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a TIMOTHY M. MILLER/SON 28102 BAILEY'S NECK ROAD EASTON, MD 21601 permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State CHESAPEARE CREMATION CENTER 1 Burial 2 X Cremation 3 Removal from State 4 Donat 04/03/2012 5 Other (Specify) STEVENSVILLE, MD . Signati FELTOWS Add FET FENBEIN & NEWNAM FUNERAL HOME, 21601 P.A. 200 SOUTH HARRISON STREET EASTON, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1 shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or): that initiated events resulting in death) Last Due to (or as a consequence of): burial physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Year 9 Unknown 9 | Unknown by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of ause of death? 24a Was an certificate has autopsy performed 2 No 1 Yes funeral director, Be 25. Was case referred to redical 26. Place of Death (Check only one) examiner? 9 Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Special SST. LIVING this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After t completely filled in by the funera Natural 5 Pending iniury ☐ Accident Investigation Suicide
Homicide Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse-Reactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu 29d. Date signed (Month, Day, Year, 725 Name and address of person eted cause of death (Item 23a) (Type, Print) 12 31. Date filed (Month, Day, Year, State 32 Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201Ž^{ea} April 3:50 P M Henry Loose Miller Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Homewood Retirement Center Williamsport Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 [Hours 06/12/1912 99 **Director** 043-07-0474 MD Usual Residence of Decedent or 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d Inside City Limits **Funeral Director** be notified 1 🗆 Yes 2 🔀 No MD Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a (16505 Virginia Ave. B312 21795 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Was Deceuent Armed Forces?

1 No Yes 2 1941-62 14. Race - American Indian, Completed by Black White etc. natural", or 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced Specify: White Year or Dates er than "naturation the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Soldier United States Military +4 other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ Victor D. Miller Nellie Loose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i 55 Plumer Road, Newton, NJ 07860 David S. Miller / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o ☐ Burial 2 🔀 Cremation 3 🗌 Removal from State 04/06/2012 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematorium Smithsburg, MD 21. Signature of Euperal Service Licenses 22. Name and Address of Facility Gerald N. Minnich Funeral Home 13,-305 N. Potomac St., Hagerstown, MD 21740 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or linjury that initiated events resulting in death) Last burial-trar physician 10 (TATE To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: use 23b. Was decedent pregnant yes, outcome of pregnancy 23d Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? for Month Pregnant at time of death 2 No the 9 Unknown Part II / Pther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe within 24 hours after death.

To the Funeral Director. After this certificate is completed filled in by the funeral director. Yes 2 No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 👿 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse R actioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signati Date signed (Month, Day, Year strar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 4:00 A Mabe1 Maria Mattingly April Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Leonardtown St. Mary's Nursing Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Min. (Month, Day, Year) **Director** 219-16-0278 1 🗌 M 2 🕱 F 87 08/01/1924 Maryland Usual Residence of Decede 28a-f show 10c. City, Town or Location notified at 10a. State 10b. County 10d, Inside City Limits Director 1 Yes 2 No Maryland St. Mary's Abe11 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 20606 38674 Collinwood Drive USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ρ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit Page 1 and 2 should be file Department of Health and Mental I. Important: If item 27 is marked any injury or and item 27 မ Katherine Maria **Quade** .Iohn Louis Knott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43542 Drum Cliff Rd., Hollywood, MD 20636 Wanda Norris/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🗷 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Catholic 4/12/2012 Bushwood, MD Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick St., Leonardtown, MD 20650 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atrial Phylician 1 22: 110500 disease or condition Medical resulting in death) Due to (or as a cons ence of): **Examiner** Sequentially list conditions cause. Enter Underlying Examir nding physician and use as the burial-transil Cause (Disease or injury that initiated events resulting in death) Last 1010001 Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atten in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) signed by the at Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No • Hospital or Attending Physician: 24 hours after death. • Funeral Director; After this certific 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4X Nursing Home 5 - Residence 6 - Other (Specify, 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 Yes 2 No Accident 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, determined City or Town, State)

Registrar DHMH 17 Rev 06-2011

State

completely

To the within 2

Medical

29a. Certifier

(Check

only one) 29b. Signatur**∉** and title of certifier

3

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KOW

non

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Suite 1A

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D070900

Kirandeep Kaur

polis

29d. Date signed (Month, Day, Year) q

29c. License number

amend 25,27,28a-f,per me,g927 5-30-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 April Physician/ 4, 5:41 A M Mildred C. Mendoza Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery g. Birthplace (State or Foreign Country) **Trinidad** If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthdav) **Funeral** Days Hours (Month, Day, Year) Director 577-06-1124 1 M 2 STF 95 March 4, 1917 and Tobago 10d. Inside City Limits 10c. City. Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at death with the Maryland Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2200 Montgomery Street 20910 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ੴ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. ģ 1 Never Married 2 Married should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black "natural". 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Trinidad and Tobago marked other than College (1-4 or 5+) Elementary/Secondary (0-12) it. Page 1 and 2 should be filed within rtment of Health and Mental Hygiene. rtant: If item 27 is marked other tha njury or other traumatic event, the I School Nursing Manager Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Johnny Evans Clarke Jestina Odeon 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline I. Mendoza / Daughter 18600 Kingfisher Terrace, Gaithersburg, MD 20879 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Gate of Heaven Cemetery 2012 1 XBurial 2 Cremation 3 Removal from State Silver Spring, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring. Com Part 1. Inter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. 23a. Part 1. Interval Between Onset and Death Immediate Cause (Final Ph sician/ Acute Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Subdural Hemorrhage ON APPROVED BY MEDICAL EXAMIN Sequentially list conditions, Examine cause (Disease or injury Deerto for se a coneccuence of Alzheimer's Dementia for use as the burial-trar that initiated events CERTIFIC Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 | Yes 2 | 9 | Unknown detached a Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law page 2 autopsy death? perform 1 ☐ Yes 2 ☐ No 1 Yes 2X No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျှ 1 X Yes 1 Manatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 🗷 No 28d. Describe how injury occurred Certificate: 5 Pending injury subject fell n 24 hours after death.

e Funeral Director; Af pletely filled in by the fu Accident Investigation fd 3-27-12 unknown M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2200 Montgomery St. Silver Spring, MD. 4 Homicide determined Home Medical 29a. Certifier 🚨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours to the completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year)

4

State

Nabila F. Khan, MD 1500 Forest Glen Road, Silver Spring, MD 20910

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

65305

April 5, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 4a,4c,610b per DVR G926 4/17/12 dk. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2012 Month **Physician** March 28, 8:00 a M Edward R. Mikulich Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rockwille Montgomery 10505 Burbank Drive (Cedar Home) Potomac Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Pennsylvania 197-28-2195 **Director** Usual Residence of Decedent with the Maryland 10b.County Montgomery Rockville 10d. Inside City Limits 10c. City, Town or Location 10a. State or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Im Medical Exportment on other traumatic event, Im Medical Exportment on other properties. MD tXXVes 2 □ No Potomac Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20854 USA 10505 Burbank Drive Funera! 12. Was Decedent Ever in U.S. Armed Forces? 1★Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1XXYes 2□No Specify: Specify: þ 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Furniture/Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Duhann Samuel Mikulich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18503 Thundercloud Road, Boyds, Maryland 20841 Edward R. Mikulich Jr. (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ¥Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawns Mem. Gardens 04-02-2012 Chambersburg, PA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Thomas L. Geisel Funeral Home of Funeral Service Licenses M01346 333 Falling Spring Road, Chambersburg, PA. Approximate Interval Between Onset and Death 23a. Part 1. Error the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stage of End Dementia **Physician** /Medical Due to (or as a consequent of); Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year After this certificate has been signed by the atte funeral director, page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. \$ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospitan C. within 24 hours after death.

To the Funeral Director. After this certificate

To the Funeral Director, pare funeral director, pare 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

DHMH 17 Rev 1/2001 20

State Registrar 29b. Signature and title of certifig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

KUKRETI

29c. License number

00052075

FIRST CLINIC, 9800, Falls Rd, Potomae MI

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DORIS MAE NAUGHTON 2012 6:37P March 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 1501 Main Street Whiteford If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth
July 4,1920 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 216-14-7111 Maryland **Director** 1 □ M 2 🔀 F 91 or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Whiteford Harford MD 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a or Examiner must be 21160 Funeral 1501 Main Street USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Maryland 21215-0036 ed other than "natural", event, the Medical Exal 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 afth and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Butch Engelhart Virginia (Unknown) other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21154 19a. Informant's Name/Relationship (Type, Print) Department of Health at Important; If item 27 is any injury or Att 1004 Taylor Road, Street, MD Deborah M. Giro/Granddau. Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Evans Eagle Crem. 3/14/12 4 Donation 5 Other (Specif Leola, PA 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA Part 1. Enter the disea shock, or heart failure se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami death certificate be executed or as a consequence of attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year , the a Pregnant at time of death 1 Yes 2 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b To the Hospital or Attending Physician: The law requires within 24 hours after death. 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an is certificate has t director, page 2 s autopsy perforr this certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ည 1 Yes 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred After PIE Natural the now thin 24 hours after deam.

o the Funeral Director: Aft Accident 5 Pending Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Jurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within To the 29b. Signature and title

State Registrar

DHMH 17 Rev 06-2011

Registrar

30. Name and address of

RODNE

erson who completed cause of death (Item 23a) (Type, Print)

722236

9105 Franklin Squar Dily

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>012</u> Physician/ Month Kathleen Wanda O'Neil 9 April Medical 9:00 p.m 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 25660 Southwell Lane Mary's Hollywood 8. Date of Birth (Month, Day, May 10, Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days Day, Ye **Director** 231-52-2111 1 M 2 X F 68 1943 Virginia Usual Residence of Deced ms 23a or 28a-f shov must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Hollywood St. Mary's 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 25660 Southwell Lane 20636 United States ıral", or iten I Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black White etc. by 1 Never Married 2 Married Yes 2 X No 1 Yes 2 X No Specify: "natural", If Yes, Give Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Director Materials Management|Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Omar Wayne Manuel Kathleen Nelson 1 and 2 should be of Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shane O'Neil-Son 25660 Southwell Lane, Hollywood, Maryland 20636 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or otl 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Brinsfield-Echols 4 Donation 5 Other (Specify) 04/11/2012 Charlotte Hall, Maryland Signature of Funeral Service Licens Santivicoci 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD Kathleen A. Santivasci MOO872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (6) as a consequence of: Examiner Sequentially list conditions, if any, leading to immediate cause. Enter *Underlying* Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death ase 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 Xivo
9 Unknown ō Month Year Day 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy yes 2 2 🗌 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural s after dea. ral Director: After 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

within 2 10) ence

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

State Registrar

31. Date filed (Month, Day, Year)

3

Jennifer Schmidt,

29b. Signature and title of certifier

person who completed cause of death (Item 23a) (Type, Print)

D.O.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

H0055751

40900 Merchants Lane, Suite 205, Leonardtown, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death Year Month A M Physician/ Maxine 6:55 March 2012 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number, Examiner Montgamery MEDSTAR MONTGOMERY GENERAL Olney If Unde If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Numbe **Funeral** Month Davs Hours Min (Month, Day, Year) Country) Director 577-32-9451 Usual Residence of De 1 🗆 M 2 😿 F 5/19/1927 MD 84 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State at 10b. County Director Examiner must be notified 1 X Yes 2 No MD Sandy Spring Montgomery 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? ö 23a 17509 Norwood Road 20<u>860</u> USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: "natura!", 3 Widowed 4 Divorced Completed Black the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Teacher - MCPS <u>Education</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mable Clagett other traumatic Richard Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a 17509 Norwood Rd., Sandy Spring, MD 20860 Harry J. Phillips/husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date permit. Page 1 Department of Important: If it 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 3/31/2012 Silver Spring, MD Signature of Funeral Serv 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St., Rockville, MD 20850 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End Ph_sician/ Stag Cancer months disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events and burial-tra Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō 5 Other (specify) Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 death?
1 Yes 2 No to the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in hy the first. certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be 1 🗌 Yes 2 No X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD 3/25/2012

Registrar

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State

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APR 0

Yuaniue

31. Date filed (Month, Day, Year)

Zhana

Montgomery

Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Phillip Drive, Olney, MD 20852

Teneral

Hospita

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:02 A M Aptort 4, Day 2012 ear Physician/ Patterson Charles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fairland Adventist Nursing Home Montgomery Silver Spring Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 216-50-5993 63 **Director** 1 🕱 M 2 🗆 F April 9, 1948 Maryland Usual Residence of Decedent r 28a-f show notified at 10d. Inside City Limits 10c. City. Town or Location 10a, State with the Maryland Director 1 Yes 2X No Silver Spring Marvland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be Funeral 20904 USA 2101 Fairland Road items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. an "natural", or iter Medical Examiner Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 X No Specify. White If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 X Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Painting Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie Bohrer Carlyle N. Patterson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health al Important: If item 27 is any injury or other trac 14 Lawrence Drive, Brick, NJ 08724 Mary C. Ekarius / Sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of April 8, cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory Alexandria, Virginia 2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 2090 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiopulmonary Arrest disease or condition resulting in death) Medical **Examiner** Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Etin to lor as a consequence of Diabetes Mellitus that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical requires that the death certificate be Hypertension Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death nse 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day ģ Pregnant at time of death 2 No 1 Yes 2 L 9 Unknown the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed t þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 🙀 No 24a Was an autopsy performed? After this certificate has Yes 2x No Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica 26. Place of Death (Check only one) completely filled in by the funeral director, 25. Was case referred to medica Be Hospital: 1 Yes 2 No Other: 4 🛛 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 XNatural 5 Pending Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Ye

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

arked

Weihan Wang, MD 15245 Shady Grove Rd., Ste. 130, Rockville, MD 20850

32. Rigistrar's Signature

29c. License number

D67092

29d. Date signed (Month, Day, Year)

April 5, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State of Maryland		rtment of H tificate of D		ental Hyوا ا	giene Reg. No. 2	012	12154		
	Physicia	n/	Registrar 1. Decedent's Name (First, Middle, Last) David VERNON		Payne		2. Date of Dea	ıth	Year	3. Time of Death 5:08 P M		
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death		4c. Count	y of Death	George's Birthplace (State or Foreign		
لمب	Funeral		Southern Maryland Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last b.	birthday)	Clintor If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt	h	9. Birthp			
	Director		. 🕅	Yrs.	Months Days	(Month, Day 7 – 5 – 1	955 955	WASI	H.,D.C.			
	/land f show ed at	tor	10a. State 10b. County 10c. City, To						1	0d. Inside City Limits		
	or 28a-	Director	MD. PRINCE GEORGES 10e, Street and Number		10f. Zip Code			10g. Citizen of	What Cour	X Yes 2 □ No		
336	n with the same same same same same same same sam	Funeral	3818 CEDAR DRIVE		2074			U.S.A				
	be filed within 72 hours after death with the Maryland ental Hygiene. *Ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 M Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates,	If	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 💢 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Bla	ice - Americ ack, White, o ^{fy:} Wh it	etc.		
-çı	72 hour matur edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupa	ation uring most of work	ing	16b. Kind of	Business Inc	dustry		
21215-0036	within 7 giene. er than , the M	Con	Elementary/Seconday (0-12) College (1-4 or 5+) 9th	life. DC	NOT use retired) DISABLE	ED		NONE	<u>-</u>			
Maryland	be filed with lental Hygiel rked other i ic event, th	To Be	17. Father's Name (First, Middle, Last) EDWARD LOUIS PAYNE, SR。			18. Mother's Nam	e (First, Middle, E JANE					
ary	1 and 2 should be if Health and Men item 27 is marke other traumatic	- 99	19a. Informant's Name/Relationship (Type, Print)		g Address (Street a	nd Number or Run	al Route Numbe	r, City or Town,	State, Zip (
	and 2 Health tem 27		EDWARD L. PAYNE, JRBROTHER 20a. Method of Disposition 20b. Place	e of Dispo	sition (Name of		R. WELC	20c. Location				
Baltimore,	. 0		1 Rurial 2 X Cremation 3 Removal from State ceme		natory or other place tan Crem	e)	i	Alexa	ndria	, VA		
Balt	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee M00479	7 22 F	Name and Addres	FUNERAL	SERVI	CE,P.	Α.			
√Physician/ ⊢ Medical			23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Due to (or as a consequence of):									
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_	rted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	N.								
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Box 687	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de 4 ☐ Pregnant at time of dear	eath 3	Ectopic pregnanc Other (specify)	у			Date of deliv	ery Day Year		
ds, P.O.	luires that the series and signed by all be detact	by	Part II. Other significant conditions contributing to death but not resulting	ng in the u	inderlying cause giv	ven in Part I.		obacco use co Yes 2		he cause of death?		
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by it completed filled in by the funeral director, page 2 should be detached.	Completed		_			1 Yes		prior to co death? 1 Yes	psy findings available empletion of cause of 2 No		
Vital	ysician s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER	NOutpatier	Oth	ace of Death <i>(Ched</i> er: 4 \(\sum \) Nursing H	ome 5 🗆 Resi	dence 6 \square O	ther (Specif	y)		
J of	Jing Phy J. After thi funeral		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) 28	Bb. Time of injury	28c. Injun work	y at :? Yes 2 □ No	28d. Describe I	now injury occu	ırred			
Division	al or Attences after death	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, str		103 2 1110	Street and Nun vn, State)	nber or Rura	l Route Number,			
	Hospita 24 hours Funera leted fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination at 3 Certifying Nurse Practioner: To the best of my knowled	nd/or inves	tigation, in my opinio	on, death occurred a	at the time, date a	and place, and (due to the ca	ause(s) and manner stated.		
_	To the within To the comp	2	29b. Signature and title of certifier		29c, License			29d. Date sign				
	Bar		30. Name and address of person who completed gluss of death (Item 20) RASHED: A - ABASSI 7503	3a) (Type, I	Print) PRATTS	ROAD.	CLINTI	JN M	10 2	0735		
	State Registrar APR 1 7 2012 APR 1 7 2012											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death			g. No. 201	2 1215						
Physicia Iedical Examir		1. Decedent's Name (First, Middle,Last) DALE ROBERT PRITTS		 Date of Death Month March 30, 	Day Year	3. Time of Death 2015 hrs						
		4a. Facility Name (if not institution, give street and number) 3271 West Dale Court 4b. City, Town, o Waldorf	or Location of Death		4c. County of Death Charles							
Funeral Director		5. Social Security Number 218-78-6605 6. Sex 1 7. Age (In yrs. last birthday) 50 Yrs. Months Da	hplace (State or n untry) MAINE									
Jaryland 28a-f show any 1.84 once.	rot	Usual Residence of Decedent 10a. State	F			10d. Inside City Limits 1 Yes 2 No						
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. Zip Code 3271 WEST DALE COURT 206	01		g. Citizen of What Cour $J.S.A.$	try?						
5 - 4	by Funeral	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No	an, Mexican, Puerto F		14. Race - Ameri White, etc.							
1215-0036 d be filed within 72 hours: lental Hygiene. arked other than "naturi event, the Medical Exami	Completed b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16a. Decedent's Usua	ual Occupation (Give kind of work done working life. DO NOT use retired) CAL ELECTRICIAN PEF			ndustry						
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MD 21 d 2 should tth and Me a 27 is man numatic cv	욘	19a. Informant's Name/Relationship (Type, Print) ROBERT D. PRITTS-FATHER 19b. Mailing Address (Streen Streen St	eet and Number or Ro	ural Route Numb		Zip Code)						
MOFE Pages 1 nent of F		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of concrematory or other place) WESLEYAN MEM • GAR	DENS 4-5	Date	20c. Location - City or	Town, State						
Balt permit Depart Impor injury	21. Signature of Funeral Service Licensee MOO479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A I.A PIATA MARVIAND 20646 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart											
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):										
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	aminer	di fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
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		IF FEMALE: 23c. If yes, outcome of pregnancy	Ectopic pregnan		23d. Date of delivery Month D	ay Year						
i, P.O. B ires that the de signed by the I be detached i		Part II. Other significant conditions contributing to death but not resulting in the underlying cause Chronic Alcohol Abuse		o use contribute to the cause of death? No 3 Probably 4 V Unknown								
Records, The law require ficate has been si , page 2 should b	Completed by			24a, Was an autops perform	opsy findings available ompletion of cause of							
tal Recians The certificate	Be		ce of Death (Check or		No 1 ✓ Ye							
Nysici	인	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA			Residence 6 🗸 Other:	Scene						
Division of Vital tal or Attending Physician: rs after death. al Director: After this certicled in by the funeral directon.	ation:	(Month, Day,Year)	Yes 2 No	28d. Describe how injury occurred								
Divis	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office (Specify)	building, etc.	28f. Location (St or Town, Sta	reet and Number or Rur ate)	al Route Number, City						
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the i	Medical (29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, cone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.										
FSFS	Ĭ	29b. Signature and title of certifier 29c. Licen	se number		29d. Date signed (Mon March 31, 2012	th, Day,Year)						
	30. Name and eddress of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223											
Sta Regist	:100	31. Date filed (Month, Day, Year) APR 1 7 2012 Security 5. April 17 2012										

State

Registrar

7845 Oakwood Road Glen Burnie, MD 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Registrar's Signatur

Amba<u>lavanar</u>

31. Date filed (Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2017 9.384 rna Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Adventist Takoma Tontgomery lashinaton If Under 1 Year | If Under 24 Hrs. Age (In yrs. last 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Hours 216-76-0639 54 Director 1 □ M 21 F May 28, 1957 Cuba 28a-f show 10d. Inside City Limits 10c. City, Town or Location : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 20910 USA 601 Wayne Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2X No Baltimore, Maryland 21215-0036 1 XYes 2 No Specify: Cuban Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Para Educator Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Teresa Nilda Iglesias Miguel Fernando Ruiz and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 Wayne Avenue, Silver Spring, MD 20910 f Health item 27 i Teresa Nilda Ruiz / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot April 10 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2012 Silver Spring, MD 22. Name and Address of Facility ins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Onset and Death Immediate Cause (Final utaneous Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ed by the attending physician and detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) 1 Yes 2 g 🗌 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 No nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, to Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\bigcap \) Nursing Home \(5 \bigcap \) Residence \(6 \bigcap \) Other (Specify) 2 | No 1 Inpatient 2 KER/Outpatient 3 I DOA ၉ 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 8c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check the 29b. Signature and title of certific 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Takoma 7600

State Registrar egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last, 2. Date of Death Redanes Hothus Month Physician/ 2012 4:13 AM April **Medical** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles La Plata Civista Medical Center If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Months Hours 1**X** M 2 □ F Director 82 181-24-9938 Yrs 12/25/1929 Lebanon Co., PA Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Charles Bryantown 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 0 ms 23a or must be n Funeral 13160 Langley Road 20617 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working r than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Disbursing Clerk Petty Officer U.S. Navy 27 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental His marked of ပ John J. Reckner Mary Moher Housel Je, h. Jernit. Page 1 and 2 sho. Department of Health and Important: If item 27 any injury or 7 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Reckner/ Wife P.O. BOX 268, Bryantown, Maryland 20617 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Salisbury I.O.O.F.Cem 04/14/2012 | Salisbury, PA 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses #M00817 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. Jan 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 30195 Three Notch Rd., Charlotte Hall, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Dirat Physician/ tou disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner wmor Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by diseane. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Other. ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Hospital or Attending Pl 24 hours after death. Funeral Director: After th Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural iniury work? 5 Pending 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, PAT) atom Blud SteB, Gilen Busine, mp

Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

DHMH 17 Rev 06-2011

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month Henry Philip Richardson, Jr. April 2012 09 Medical 3:45P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 13301 Croom Road Upper Marlboro Prince George Social Security Number 7. Age (In yrs. last birthday) 6. Sex If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Min (Month, Day, Year) **Director** 213-38-3620 1 X M 2 □ F 72 09/16/1939 Westwood, MD Usual Residence of Decedent show and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show in matic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 XNo MD Prince George Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13301 Croom Road 20772 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White Specify: Completed 3√X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Sign Mechanic Elementary/Secondary (0-12) College (1-4 or 5+) 6th III/Traffic Service Worker IV P.G. County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Ments. Important: If item 27 is marked any injury or out. 2 Henry Philip Richardson, Sr. Mildred Teresa Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl A. Farrell / Daughter 3301 Croom Road, Upper Marlboro, MD 20772 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/17/2012 | Clinton, Maryland Resurrection Cem. of Funcial Service Licenses 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. hre #M00817 30195 Three Notch Road, Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final lated Onset and Death Physician. Cardio myopali years disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Moul Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of) attending physician I for use as the buris Physician/Medical death certificate be P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Control of time of death 5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? has page 2 After this certificate 2 🗆 No 1 Yes Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Pesidence} \) 6 \(\text{Other} \) Other (Specify, 1 ☐ Yes 2 ☑ No ည 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury Natural work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 2012 D042 049 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) upper Marlboro MO MD hampalou.

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 24a per med cert G926 4724/12 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day REINHART 12.14 PM CHALLES APLIL 2012 0.1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD GRACE HARFULA HAURG DE MSMOURE HOSPITAL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/11/1954 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🕱 M 2 🗆 F Months Days Hours Min. **Director** 217-62-5175 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No MD Cecil Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19B Owens Landing Court USA 240/2012-01 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 No Yes, Give ρ "natural", or 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify. Specify: Completed 3 Widowed 4XXDivorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour popartment of Health and Mental Hygiene. Important If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Investigator Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file John K. Reinhart Sarah Coulson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John C. Reinhart, Jr. - son Richmond Street, Perryville, MD 21903 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 04/04/12 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.T. Foard Funeral Hm. PARising Sun, MD 21. Sign Le uneral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, PA ich a. 259 East Main Street, Elkton, MD 21921 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one carries on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ANOXIC EN CEPHALOPATHY disease or condition 9HRS Medical resulting in death) Due to (or as a consequence of) Examiner CALAJAC ARREST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit INFALCTION MYOCARDIAC Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day ed by the a g Unknown g Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETTS MELLITUS, HYPELTENSION 1 Yes 2 No 3 Probably 4 Unknown HYCERLIPIDEMIA, MURBIA OBECITY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Hospital or Attending Physician; Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No မ 1 Ninpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral i 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 121338 4 ARIC. 1. 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 LAN SWEATTAN , HARPINA METIOCIAL HOSPIFAZ, KAVE au GRACE. 171 21078 APR Year) 31. Date filed (Month, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ 30 10:58 PM March Mary Louis St. Leger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester Atlantic General Hospital Berlin Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Director 212-24-7698 1 🗆 M 2🔀 F 82 Yrs. 5-12-1929 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State must be notified at Funeral Director 1 Yes 2X No MD Ocean City Worcester 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 12012 items 23a 21842 104 Old Landing Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. 0 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: 3√ Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Social Worker State of Maryland nand Mental Hygier Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fill.
Department of Health and Mental
Important: If item 27 is marked of any injury or other traumatic eve ည George L. Schanze Grace Hillficker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael St.Leger-Son 5504 Kenwood Ave. Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State First State Crem. 4-2-2012 Millsboro, DE 4 Donation 5 Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 108 William Street Berlin, MD 21811 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ik, or heart failure. List only one cause of each line. shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Plusician/ neumone disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical $\sum \mathcal{L} \mathcal{L} eqe_{\mathcal{L}} / \mathcal{L}$ Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performe 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) To the Hospital or Attending Physician: Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending within 24 hours arter community the Funeral Director: After the Funeral Director and the further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further further furth Accident 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office uilding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical g Physician: To 🖟 e best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Ceptifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year) 53612 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAIL

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

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2012

Registrar's Signature

03/30/

for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 Physician/ 29^{Day} Francis X. Snoots Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Atlantic General Hospital Berlin If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 267-53-6432 **Director** 1 XM 2 □ F 00) 03/29/2012@ 0430 48 4/9/1963 Usual Residence of Decedent 28a-f shov items 23a or 28a-f shoner must be notified at 10a. State 10b. County 10c. City, Town or Location Director MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 712 Bahia Dr. 21842 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) er than "natural", or iter the Medical Examiner Armed Forces? by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e should be filed within 72 l h and Mental Hygiene. 7 is marked other than "n life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) n/a 10 Be 17. Father's Name (First, Middle, Last) ၉ other traumatic Lawrence E. Snoots 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other trac Lawrence E. Snoots father 712 Bahia Dr., 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4/2/2012 First State Crem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility 108 William St., 23a. Part 1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ as disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a Was an page 2 s certificate Division of Vital funeral director, 25. Was case referred to medical or Attending Physician: 26. Place of Death (Check only one) Be examiner? Hospital 1 Yes 2 No ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Man of Death 28b. Time of Certificate: 28c. Injury at Natural 5 \square Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital 29a. Certifier (Check only one 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item; 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

18. Mother's Name (First, Middle, Maiden Surname) Margaret Hagerhorst 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oce<u>an City, MD</u> 20c. Location - City or Town, State Millsboro, DE Burbage Funeral Home Berlin, Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Numbe Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Day, Year, Dr. Berlin MD 32. Registrar's Signature ORIGINAL

201

USA

Specify:

n/a

14. Race - American Indian

white

Black, White, etc.

Worcester

4c. County of Death

4:30

Birthplace (State or Foreign Country)

10d. Inside City Limits

1X Yes 2 No

Washigton DC

A

DHMH 17 Rev 06-2011

State Registrar Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Stafford Letitia Jaclyn 29 2012 5:30 Α March Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Oueen Anne's Oueen Anne 309 Mason Branch Road 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Funeral Days Hours (Month, Day, Year 1 □ M 2 🔀 F 221-18-8651 81 March 01.1931 Director Delaware Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County Director Queen Anne's 1 Yes 2 X No MD Oueen Anne 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21657 309 Mason Branch Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No 3 X Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Mentally Ill Caretaker Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ပ Alice P. Warrington permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic s Joseph J. Heintz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 Mason Branch Road Queen Anne, MD 21657 Deborah Thompson/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) March 30, 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD Metro Crematory, 4 ☐ Donation 5 ☐ Other (Specify) INC 2012 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
CREMATION DIRECT Severna Park, MD 21146 495 Ritchie Hwy 23a. Part 1 Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CONGESTIVE Ment disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner Due to (or as a consequence of) if any, leading to immediate cause Enter Underlyin Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No Day for Pregnant at time of death 5 Other (specify) Unknown been signed by the a should be detached t the 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No page 2 s 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of th 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29d. Date signed (Month, Day, Year, 29c. License number 29b. Signature and title of

CH3

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] | 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month March 30, 11:15 AM Norman Kenzie Smith Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Jefferson Frederick 3836 Jefferson Pike 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral Hours **Director** 219-40-0194 1 **X** M 2 □ F 70 Dec. 29, 1941 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Funeral Director 28a-f 1 🗆 Yes 💥 No Maryland Frederick Jefferson 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r 3836 Jefferson Pike 21755 U.S.A. death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Examiner Black, White, etc. þ 1 Never Married 2X Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Owner/Operator Clock Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Norman Wilson Smith Sandra Willingham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher K. Smith - Son 19313 Betty's Avenue, Boonsboro, Maryland 21713 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify) Meadowridge Cemetery 4/5/2012 Elkridge, Maryland Signa ure of Fu eral Service picensee Name and Address of Facility Molesworth-Williams P.A., Fu 26401 Ridge Road, Damascus, Lovers Funeral Home d 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Sudden candiac disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine ri arry, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ abrtic 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 X - diabetes 2 🗆 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural 5 Pending work?
1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Kathleen W. Stern,

APR

DHMH 17 Rev 06-2011

Bem

32. Registrar's Signature

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D32073

4014 Mountville Road, Jefferson, Maryland 21755

29d. Date signed (Month, Day, Year)

April 2, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Abril 3. P2Y012 Helen C. Smith 6:15 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Wilson Health Care at Asbury Village Gaithersburg Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country Virginia 1 - M 2 X F Hours Min Sep. 12, Year) 1926 Director 579-40-5185 Usual Residence of Decedent shov 10a. State 10b. County with the Maryland event, the Medical Examiner must be notified at 10c City Town or Location 10d. Inside City Limits Director or 28a-f 1 Yes 2X No Maryland Montgomery Silver Spring 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral items 23a 9210 Mintwood Street 20901 USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Black, White, etc. ŏ 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", 3 ₭ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. d other than " Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked ot ဂ္ Cornelius Prosner Isabella Unknown t. Page 1 and 2 should by thent of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce M. Smith / Son 9210 Mintwood Street, Silver Spring, MD 20901 other 20a. Method of Disposition 20b. Place of Disposition (Name of April 5 20c. Location - City or Town, State Department of I Important: If its any injury or of 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State cemetery, crematory or other place) 2012 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, Virginia Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 2090 23a. Part 1. Enter the disease, or complications that caused ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Nypertensive arterioschrotie side vicente Onset and Death Pnysician/ disease or condition Medical resulting in death) Da to (or as a consequence of): xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 deler After this certificate 1 ☐ Yes 2 ☐ No Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tyes 2 1 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manual of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Suicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29h. Signature and title of certifier Willyber Torsubsch MD, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUSS ELL LD BIRSCHOSCH, MI GAITHERS BURE, WID Registrar's Signature 31. Date filed (Month) State Barke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ р Arrington Evan Scott March 30 2012 3:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14107 Heathfield Court Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Days Hours (Month, Day, Year) 579-36-1034 82 **Director** 1 M 2 X F 1930 North Carolina March 13, Usual Residence of Decedent show 10c. City, Town or Location 10b. County 10d. Inside City Limits must be notified at Director 28a-f 1 Yes 2 X No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 14107 Heathfield Court 20853 USA of Health and Mental Hygiene.
item 27 is marked other than "natural", or items
other traumatic event, the Medical Examiner mu death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black White etc. ģ 1 Never Married 2 Married 1 Yes 2X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify. Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Medical Staff Secretary Health Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Reid Arrington Marjorie May Pritchard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traus Michael James Scott / Son 14202 Wolf Creek Place #12, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 6, 1 🖁 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 2012 22. Name and Address of Facility Funeral Home, Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Ureteral Cancer Year Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Other (specify) 1 Yes 2 E g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, cate has been sig r, page 2 should b 1 Yes 2 x No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has autopsy perform 1 Yes 2 XNo 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) 2X No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending iniurv 2 Accident Investigation within 24 hours after death To the Funeral Director. Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🛮 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of cor 29d. Date signed (Month, Day, Year) 29c. License number 12 30. Name and address son who completed cause of deeth (ftem 23a) (Type, Print) Rd 0 MALT 330 OC MD 31. Date filed (Month 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sajovic 9:10PM 3013 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner JuliaManor Washington Healthcase Hagerstown Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 217-38-5260 **Director** 71 1 🗆 M 2 🕱 F Virginia April 16,1940 28a-f show 10d. Inside City Limits and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at 10c. City, Town or Location death with the Maryland Director Hagerstown 1 X Yes 2 No Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 USA 931 Chestnut Street 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 Yes If Yes, Give and 2 should be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Completed Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) food plant factory worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evence. Myrtle Irene Angles Claude Allen Godsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 421 Joyce Dr., Glen Burnie, Maryland 21061 Kenneth Godsey - brother Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Pleasant View Mem.Gdn\$. 4/6/12 Kearneysville, WV 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final . Ph, sician/ Metastatic Neodlasm disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or injury the burial-transit Atheroscleratic and that initiated events resulting in death) Last Due to (or as a consequence of been signed by the attending physician should be detached for use as the buria Physician/Medical or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 1 ☐ Yes ∠ y 9 ☐ Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records. 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has I 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner?
1 Yes Hospital Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Director: After 1 X Natural 2 Accider 5 Pending work 1 ☐ Yes 2 ☐ No completely filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🔀 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the 30. Name and address, of person who completed cause of death (Item 23a) (Type, Print) CANP-333 Mill Street, Hagerstown, MD 21740

State Registrar DHMH 17 Rev 06-2011 a Naden-Blucher

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ Robert Erich Shipp, Sr 2012 April 5:30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans Home Charlotte Hall St. Mary's 5. Social Security Number 6. Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth . Age (In vrs. last birthday) **Funeral** Months Hours Mir 06/20/1943 Yrs 68 Director silesia MD 214-42-6451 Usual Residence of Decede 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes XX No MD Prince George Suitland 10e Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 4303 Donna Street 20746 items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Hygiene. other than "natural", or iter ent, the Medical Examiner Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) D.C. Government other Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ၉ other traumatic Thomas Shipp Annie Roach Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Robert E. Shipp, Jr. 841 Westbourne Drive, Unit B. West Hollywood, CA 90069 Baltimore, 20a. Method of Disposition
1 □ Burial 2 ☒ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Brinsfield-Echols Crem 04/07/2012 | Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fun Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. Men #M00817 30195 Three Notch Rd., Charlotte Hall MDor complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between shock, or heart failure. List one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) quence of Due to (or as a cont Examiner Sequentially list conditions, if all y, leading to incrediate cause. Enter Underlying Examine Date to for est a nonsecutarion of anding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending newalvia P.O. Box 68760 fyes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death Yes ∠ Unknown signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed pluous 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy pace 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Hospital ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1
Yes 28d. Describe how injury occurred injury 1 V Natural 5 Pending 2 **/** No Investigation Accident completed filled in by the 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person wh

APR 09

of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 21 per FH/DVR G926 4/20/12 dk

State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARCH 3:15AM Emelia Sabo1 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Reeders Memorial Home Washington Boonsboro If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral (Month, Day, Year) 1 □ M 2 🛭 F Days Hours Min New York Months 82 **Director** 132-20-5566 Aug Usual Residence of Decedent or 28a-f shov notified at 10a. State 10h County 10c City Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Washington Maryland | Boonsboro 10e. Street and Number 10f. Zip Code o 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 141 South Main Street 21713 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2X No Specify: 3 Midowed 4 □ Divorced Specify: Completed White 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Owner Grocery is marked other traumatic event, Be AME: JABOL Baltimore, Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ludwig Hydzik Julia Sztuka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Kenneth Sabol/Son 182 Wyghtman Avenue Norwich, Connecticut 06360 Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Calvary Cemetery 04/04/2012 Queens, New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bast-Stauffer Funeral Home PA Randall L. Weagley per DVR 7606 Old National Pike Boonsboro, MD 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SBASUS disease or condition resulting in death) 30445 Medical Due to (or as a consequence of): Examiner 2-30AYS Praumon (A Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examiner Due to (or as a consequence of): and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) detached us veruncate has been signed by the director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CARDIO ARTERIO SCLEROTIC VASCLLOR Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of MALLITUS MERSON ORESITY SLEEN 24a. Was an After this certificate has autopsy performed Lypsthyeo 10 UM MYPER ZENSION To the Hospital or Attending Physician: The lawithin 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပု 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred work? 1 \(\subseteq \text{Yes} \quad 2 \(\subseteq \text{No} \) 1 Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) APRIL 2, 2012 D018019 a mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET HAGERSTOWN MARYLIAND 21740 VASANT 340 MILL 31. Date filed (Month, Day, Year) State APR O 4 Registrar

EMELIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State Registrar

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1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month dred Sweener 9:20 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sun Valley Meadows Assisted Living Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** 579-24-2039 1 - M 2XX **Director** 87 02/11/1925 MD 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified MD Carroll Westminster 1 Yes 2XXNo 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 4113 Ridge Road 21157 USA items 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify: White Completed 3 Divorced 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) Professional Assoc. & College (1-4 or 5+) the Clerical Society of Am. Engineers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ira Worthington Florence Custer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 21157 28 Bella Vita Ct., Apt. 3-B, Westminster, MD Richard Sweeney/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 04/02/2012 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 103/28/2012-Cheltenham, MD Signature of Funeral Service Licensee 22. Name and Addres Prints Funeral Home and Chapel, P.A. 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyi shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ menar 4 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death g Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy perform death? certificate ☐ Yes Yes To the Hospital or Attending Physician: 25. Was case r Be 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at eral Director: After i filled in by the funer 1 Natural 5 Pending injury work? 2 🗆 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Na

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ື2012 April 9, 5:01 p Helen Marie Schmidt М Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster If Unde 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number . Age (In yrs. last birthday) Months Min 215-01-7357 Director 1 □ M 2 🎽 F 93 July 27, 1918 Maryland Usual Residence of Decedent or 28a-f show notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? ms 23a o Funeral 1539 Brehm Rd. 21157 USA items? death Was Deceus.
Armed Forces?
Ves 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iter Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 ☑ Widowed 4 ☐ Divorced Specify: Completed White Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) e 1 and 2 should be filed within 72 to f Health and Mental Hygiene.
If item 27 is marked other than "r or other traumatic event, the Med (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Allied Paper Baq Machine Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ William Arthur Wingfield Caroline Almeria Page 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Schmidt/Son 3507 Glenwood Rd. Baltimore, MD 21220 Department of Healtl Important: If item 2 any injury or other to Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc 4/11/2012 | Hampstead, Maryland ture of Funeral Service Lig 22. Name and Address of Facilitaritts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the burial-tra Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 38 IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4, Unknown Completed should Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed' death? 1 🗌 Yes _ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specific Notice) Other: 1 Yes 2 WO မ 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this funeral 28a. Date of injury (Month, Day, Year) 27. Manne f Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No filled in by the Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurs Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur d title of certifier signed (Month Day, Year) Date estminister MU 21157

State Registrar 31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ome Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomer PARK AKOMA Adventi 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. **Funeral** 579-76-3202 **Director** 1 M 2 🗆 F 55 South Carolina 101 f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ✓ Yes 2 ☐ No ashina 10f. Zip Code 10g. Citizen of What Country? 20744 Funeral 5. · ddle 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Compute Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Margaret Manle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington, MD 20744 Margaret A. Toomer Mother Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o cemetery, crematory or other place, itan Crematery 4/5/2012 Alexandra, Va.
22. Name and Address of acility Phillip Bell & W. Morerisse the Johnson
2107 Carl Ct. According 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematery 4 Donation 5 Other (Specify) 21. Si pat re of Funeral Service Licenses 2107 Carl Ct. ACCOKEEK, MD. 2060-7 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sis Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Physician/Medical Examine Due to for as a consequence of cause. Enter Underlying use as the burial-transit **To the Hospital or Attending Physician:** The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last signed by the attending physician and do be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' 1 Yes 2 No certificate director. 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) funeral 28c. Injury at work?
1 Yes 2 No 27, Manner of Death 28b. Time of 28d. Describe how injury occurred iniury 5 Pending 1 Natural s after death. Accident Investigation the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0060100 31-12 MO Ð 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gra cos 10 Silver In MO 20 90 3 MO

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 4 2012

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar amend 7 per b.c. g927 5/11/Janzifletate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mo31/27/2012 0720 Abigail Ann Tangrea Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis Social Security Number If Under 1 Year If Under 24 Hrs 6. Sex . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2XXF Months 3/27/2012 Director UNK 0 Usual Residence of Decedent 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No 0denton MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21113 USA 2420 Beechnut Pl. death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. Never Married 2 Married Completed by XIX No ☐ Yes Baltimore, Maryland 21215-0036 72 hours after White 1 ☐ Yes XX No Specify: If Yes, Give "natural", 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michelle Malat Michael Tangrea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2420 Beechnut P1. Odenton, MD 21113 Michelle Malat Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date injury or 1 XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Our Lady of the Fields 3/31/2012 | Millersville, MD Signature of Funeral Semile Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ANEN CEP disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) sician and burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Fecords, P.O. Box 68760 as the t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day 5 Other (specify) Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗆 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law autopsy performer 1 Yes Division of Vital completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Natural work?
1 Yes 5 Pending 24 hours after death Funeral Director: A Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined To the Hospital Medical 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) MD D36143 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

W

Registrar

State

31. Date filed (Month, Day, Year)

APR 03 2012

Myrna Ortega 2001 Medical Parkway Annapolis, MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ffrey Stephen		fner State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar Certificate of Death Reg. No.	2 2 7									
Physici edical Exami	an/	1. Decedent's Name (First, Middle,Last) ZEFFREY STEPHEN UFFNER 2. Date of Death Month Day Year April 5, 2012	3. Time of Death 0427 hrs									
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Galena Kent										
Funeral Director		5. Social Security Number 222-78-8375 6. Sex 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. l										
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and 2 s and 2 s realth ar item 27		Stephanie Fletcher (Mother) 6052 Millington Rd. Clayton, DE. 19938 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or										
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		30. Name and address of person who completed cause of death (Item 23a)										
	ate	Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Begistrar's Signature										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Waters 6:28 AM 30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Inthicum 4nne House Date of Birth (Month, Day, Year) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 24-0331 Director 1 M 2 X F 85 15-Marybud Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Director 1 Yes 2 No Maryland 10e. Street and Numbe 10g. Citizen of What Country? Funeral 3604 USA 20772 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🐼 No 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify "natural", Completed 3 X Widowed 4 Divorced Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the tomemoken 12 Be 17. Father's Name (First, Middle, Last) ပ္ Brooks John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between set and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a coase quence of **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: nse s 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 □ No 3 □ Probably 4 🕱 Unknown Division of Vital Records, 1 Yes Completed . Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy page 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 🗓 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pendina 1 Yes 2 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 64234 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20735 Moodyard egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death March Physician/ 3 Medical acility Name (if not institution give street and number City, 4c. County of Death **Examiner** of more 1 Year If Under 24 Hrs.
Days Hours Min. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) **Funeral** Months **Director** 228-64-2077 1 🗆 M 2 🗶 F Yrs. 64 MARYLAND SEPT.30,1947 Usual Residence of Decedent fshow or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD QUEEN ANNE'S CENTREVILLE 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21617 USA 208 GROVE COVE ROAD permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examinar m... 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) TRANSPORTATION SCHOOL BUS CONTRACTOR 12 -0-Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ HELEN BULL ALBERT WATERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 GROVE COVE ROAD, CENTREVILLE, MD 21617 DONALD WILLIS/HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State CHESAPEAKE CREMATION 1 Burial 2 X Cremation 3 Removal from State APRIL 4, STEVENSVILLE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME,
408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Due to for the attending physician and hed for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death 1 Yes 2 Unknown be detached g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has page 2 performed² 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral Manner of Death Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) work? 1 Yes 2 No 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of certifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) VM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2012 Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03/26/2012 3:30 P AUDREY LUCILLE WASHINGTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery 1316 Fenwick Lane, #507 Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Hours Months Days 12/13/1924 87 **Director** 438-20-0902 Usual Residence of Decedent 28a-f sho 10a. State the Maryland 10c. City. Town or Location 10d. Inside City Limits Directo notified Silver Spring 1 XYes 2 No MD Montgomery 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? pe 23a Funeral 20910 1316 Fenwick Lane, #507 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
sint. If item 27 is marked other than "natural", or items uny or other traumatic sevent, the Medical Examiner mury or other traumatic sevent, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 X Divorced Specify: Black Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Clerk Court Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Pershing Boutte Amalie Dave 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1316 Fenwick Lane, #507, Silver Spring, MD 20910 Vanessa Clarke/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State Parklawn Memorial Pk: 04/04/2012 Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home Signature of Funeral Servi 1101576 246 N. Washington St, Rockville, MD 20850 104 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Failure to thrive disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Advanced alzheimer's dementia Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 \square Yes 2 $\begin{tabular}{ll} X \end{tabular}$ No 3 \square Probably 4 $\begin{tabular}{ll} \Box$ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 X N 2 🗌 No 1 🗌 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 2 XNo Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this s after deau..
al Director: After the in by the funer? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by . Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital within 24 hours To the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 03/27/2012 MD21791 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 106 Trying Street, NW, #403, Washington, DC 20010 Emmanuel T. Mbualungu, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 –** For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2012 Month Physician/ 11:45 P M March 30 Martha Wolfsohn Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not Institution, give street and number) Examiner Annapolis Anne Arundel Heritage Harbour Health Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey 7. Age (In yrs. last birthday) 8. Date of Birth 5, Social Security Number **Funeral** 1 □ M 2 🗓 F Months 4/10/192 90 140-10-3039 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State rritems 23a or zoonust be notified at Director 1 X Yes 2 □ No Hudson North Bergen NJ 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 07047 8411 Grand Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Fabrics Saleswoman 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose Denanno ပ Anthony Ciccarelli 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 371 Berkshire Drive, Riva, Maryland 21140 Debra Aguiar/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 X Removal from State Fort Lee, New Jersey 4/2/12 Madonna Mausoleum 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Sign we of Fungray sen 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the gode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause a each live Immediate Cause (Final Paysician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death the g | Unknown has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 2 🗌 No Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred work? Natural injury 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d, Date signed (Month, Day, Year) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP 6934 Aviation Blvd., Glen Burnie, MD 21061 Diana Ng,

Registrar

State

Date filed (Monta)

32. Revistrar's Signature

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			For State Registrar	State of Ma	aryland /		tment of ficate of		and M		giene Reg. No.	201	2 2	80	
	Physicia Medi		1. Decedent's Name (First, Middle, Last)	Haynes Mofikpara Wright						2. Date of Death Month March 30			3. Time of De 2 221	ath M	
	Examir		4a. Facility Name (if not institution, give s Holy Cross		4b. City, Town, Silv	or Location			County of Dea Mov	tgomery					
	Funeral Director		5. Social Security Number 6. Sex 214-45-2302 1 [2] Usual Residence of Decedent	 	(In yrs. last b	Yrs.	If Under 1 Year Months Day		24 Hrs. Min.	8. Date of Bir (Month, Da 11/27	y, Year)	Co	thplace (State or Fountry)	_	
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121215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy righty or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	10233 Cabery R 11. Marital Status 1 Never Married 2 M Married 3 Widowed 4 Divorced	2. Was Decedent Every Armed Forces? 1 ☐ Yes 2 図 In If Yes, Give Year or Dates.		lf \	s Decedent of es, specify Cu	ban, Mexica	igin? (Spec n, Puerto F	cify Yes or No- Rican, etc.)		Sierro 4. Race - Ame Black, Whit pecify:			
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Baltimore,			1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Gate	of He	tory or other pi	em.	04/14	4/2012	Silve		ing, Mary		
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092	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequenc	e of):									
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Division	al or Atter s after des al Director ed in by th	al Certificate:									28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	Medical	(Check 2 Medical Examine only one) 3 Certifying Nurse	ian: To the best of ner: On the basis of experience: To the	amination and	d/or investiga	ation, in my opi	nion, death o	ccurred at t	he time, date a	nd place, a	ind due to the	cause(s) and manne	r stated.	
	with To		29b. Signature and title of certifier	m.d.				se number)66249				signed (Montl			
	5		30. Name and address of person who con Jonathan Duran, N	.D., 1500	Fore	st Gle	en Road	, Silı	ver S	pring,	Mary	land 21	910		
	Sta Registra	te ar	31. Date filed (Month, Day Year) 5 20	32. Begistrar	's Signature	1. 160	iles								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Nama (First, Middle, Last) Year 7:10 AM **Physician** a 301a Wolfe Mildred /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner Golden Living Center Krederick Frederick 8. Date of Birth
(Month, Day, Year)
July 2, 1923 9. Birthplace (State or Foreign If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number Days Country) Maryland **Funeral** Months 1 ☐ M 2 🖾 F 88 Yrs. 214-54-0374 Director Usual Residance of Decedent 10d. Inside City Limits the Marylend 10c. City, Town or Location 10b. County 10a. State 28a-f shov traumatic event, the Madical Examiner naust be incitited at 1 ☐ Yes 2 No Myersville Director Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Peges 1 end 2 should be filed within 72 hours efter death with I nent of Health end Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or items 23a. 21773 3976 B Wistman Lane Be Completed by Funeral 14. Race - American Indian, Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Tes 2 No Specify: Specify: white 3 Nidowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) her own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie Mae Long John Alvey Fink 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3976B Wistman Lane, Myersville, Maryland 21773 Michael A. Wolfe - son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Mathod of Disposition metery, crematory or other place) Depertment of Important: If its any injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Hagerstown, Maryland 4/5/12 Hagerstown Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Eignature of Euneral Service Licene E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ORDIVAKY Examiner ACCIDEN EVE BROVASCULMA Physician/Medical Examiner for use es the buriel-transit or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. is certificate has been signed by the edirector, page 2 should be deteched 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Be Completed TLIYES 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Medicai Certification: To this 28c. Injury at Work? 28d. Describe how injury occurred ar death. 28b. Time of 27. Manner of Donth 28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 🗆 No 2 Accident efter death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyaiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Holical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

State

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Toll

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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37 Registrer's Signaty

KAZMI.

House Ave. FREDERICK

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>012</u> Month Physician/ April 6 Medical <u>Eleanor</u> <u>Ernestine</u> Wormwood 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 40852 Spring House Lane Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year, Director 219-48-6433 1 M 2X F 65 Usual Residence of Decede 11/28/1946 Washington, D.C show with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 🗆 Yes 2🔽 No Leonardtown Maryland St. Mary's 0 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral United States 20650 40852 Spring House Lane items death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian and Mental Hygiene.

is marked other than "natural", or iter
aumatic event, the Medical Examiner i Armed Forces? Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: White 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education Professor injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Eleanor Pogue Ernest Hodges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i 40852 Spring House Lane, Leonardtown, MD 20650 Sydney Sgambato / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of F Important: If ite any injury or ot once. cemetery, crematory or other place, 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield Echols Cre 04/10/2012 Charlotte Hall, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Brinsfield Funeral Home M01403 22995 Hollywood Rd., Leonardtown, MD 20650 Danielle Ward 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Metastatic Dilast cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy jo in the past 12 months?
1 ☐ Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the at Id be detached for Unknown P.O. Hospital or Attending Physician: The law requires that the 24 hours after death.
 Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy page 2 1 Yes 2 No Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation completely filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical L'Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Within 2 To the F only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License numbe D71807 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40900 Merchants in Ste 207 Leonardtwn, mD

State Registrar

Saran

A 31. Date filed (Month, Day, Year,

Johnson

APR 0 9 2012

DHMH 17 Rev 06-2011

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month 0.3 Physician/ PM Oalx a Medical 4a. Facilit ame (if not institution, give street 4b. City, Town, or Location of Death County of Death **Examiner** 4nne MARIPO 11 43 Mind Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** (Month, Day, Year) 66 212-44-2695 **Director** XX M 2 \square F 4/8/1945 MD Usual Residence of Decedent 28a-f show 10d. Inside City Limits or items 23a or 28a-f sho miner must be notified at 10a. State 10b County 10c. City, Town or Location the Maryland Director Arnold 1 Yes XX No Anne Arundel MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21012 522 Bay Green Dr. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian 2 should be filed within 72 hours after deat the and Mental Hygiene. 27 is marked other than "natural", or iten traumatic event, the Medical Examiner is Was Decedent Ever III 0.3.
Armed Forces?
XXYes 2 □ No Vietnam
If Yes, Give
Year or Dates. Black White etc þ 1 Never Married 2 XX arried Baltimore, Maryland 21215-0036 White 1 ☐ Yes XX No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) US Army Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Page 1 and 2 should be 1 Bernice Bulette John David Yarbro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i 522 Green Bay Dr. Arnold, MD 21012 Wife Lynn Yarbro 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial XX Cremation 3 Removal from State 0 Department of Important; If any injury or once. 3/31/2012 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph. sician/ disease or condition resulting in death) Medical as a consequence of) Due to (or **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Dua to for selection equence of attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death 2 No g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work?
1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signat re and title of certifier License number 29d. Date signed (Month, Pay, Year) Name and address of person who completed cause of death (kem 23a) (type, Print)

State

Registrar

3 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month Day Jav Belden Young Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death West River 5079 Muddy Creek Road Anne Arundel Social Security Numbe **Funeral** 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 213-58-5747 **Director** 1 X M 2 - F 58 Yrs September 25,1953 Washington, DC 28a-f show Ħ 10b. County 10c. City, Town or Location Director notified 1 Yes 2 X No West River Maryland Anne Arundel ò 10e, Street and Number 10f. Zip Code tem 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 10g. Citizen of What Country? Funeral 5079 Muddy Creek Road 20778 USA death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) ò 1 Never Married 2 X Married Black, White, etc. ☐ Yes altimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify If Yes, Give White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b, Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. life. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) Executive Management **Healthcare** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel Morris Young Margie Lee Smithwick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Sherrie Young/Wife 5079 Muddy Creek Road, West River, Maryland 20778 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Date cemetery, crematory or other place)
Kalas Crematory 1 Burial 2 X Cremation 3 Removal from State 3-31-2012 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Ineral Se 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Forter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph. sician/ espirati disease or condition weels Medical resulting in death) Examiner Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Examine Due to for as a some-some burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Day Pregnant at time of death Month Year 2 No the a detached g Unknown a Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown neec 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has page performed death? 1 Yes 2 XNo Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending ithin 24 hours after death.

the Funeral Director: After ompletely filled in by the fun 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52756 March 30, 2012 aur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print fensetting HNNAPolis MD 21401 trar's Signature State Registrar

DHMH 17 Rev 06-2011

amend #4a Beate PHY G927 5/10/2012 JH
amend #4b Per PHY G927 Certificate of Death

Reg. No. for State Registrar 12185 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Harry Eugene Yaukey, Sr. 2012 8:20 A M April Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Leonard town.
Char Lotte Hall. 4c. County of Death Examiner St. Mary's If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Sex 1 🕅 M 2 □ F 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Yrs Chambersburg, PA **Director** 218-26-1251 81 09/09/1930 Usual Residence of Deceder 28a-f shov 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No MD Charles Newburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14425 Anchorage Acres Drive 20664 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed White and Mental Hygiene.
is marked other than "natu
aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State Police Trooper First Class Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Myra Lolleta Reeder Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myra A. Hardesty / Daughter 27 permit. Page 1 and 2 Department of Health Important; If item 27 any injury or other tr once, 8385 Dents Lane, Charlotte Hall, MD 20622 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veteran Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/19/2012 Cheltenham, MD 21. Signature of Funeral Arvice Licenses 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. #M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Aspiration Immediate Cause (Final Onset and Death Ph_sician/ PHEUMONI disease or condition Medical resulting in death) as a consequence of): Examiner Sequentially list conditions, Examine If any leading to immedicause, Enter Underlying burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Artery Ordnary Diseas Due to (or as a consequence of) physician Physician/Medical ementia $\gamma\mathcal{H}\mathcal{K}$ Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months?
1 ☐ Yes 2 ☐ No for 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 1 Yes 2 L 9 Unknown the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed 1 Yes 2 No 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1- Natural 5 Pending Accident Investigation by the 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 068933 2 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vijaya L. Guduri, MD; Philip J Bean Med Ctr.; 24035 Three Notch Rd; Hollywood, MD 2063 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Bonnie Ruth Zevin 0051 April 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda Suburban Hospital Montgomery 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Days Min 577-24-4481 1 □ M 2 🕱 F 87 July 03, 1924 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits Maryland Chevy Chase 1 Yes 2 X No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2701 Spencer Road 20815 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married

1 ☐ Yes 2 X No Specify

(Give kind of work done during most of working life, DO NOT use retired)

Grant Administrator

16a. Decedent's Usual Occupation

Specify:

Martha Altheld

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16220 Frederick Road, #213, Gaithersburg, MD 20877

16b. Kind of Business/Industry

of Health

White

National Institutes

injury or other traumatic permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other. hysician/ Medical Examiner

Physician/

Medical

Oa. State

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

If Yes, Give Year or Dates

College (1-4 or 5+)

5. Decedent's Education

(Specify only highest grade completed)

David Nathanson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Schoenberger,

M.D.,

gistrar's Signature

Director

Funeral

þ

Completed

Be

မ

Examiner

Funeral

Director

28a-f shov items 23a or 28a-f shoner must be notified at

ed other than "natural", or itelevent, the Medical Examiner

ul Hygiene.

n and Mental Hygier 7 is marked other 1

death with the Maryland

within 72 hours after

Baltimore, Maryland 21215-0036

12:00

Box 68760

P.O.

Records,

of Vital

Division

the Hospital or Attending Physician: The law

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Examiner Completed by Physician/Medical signed by t d be detact Be (filled in by the funeral director မ Medical Certificate: within 24 hours a

To the Funeral I

Susan Zevin - D	aughter 233	Cape St.	John Road,	Annapolis.	Maryland 2	1401
20a. Method of Disposition		isposition (Name of crematory or other pla	Da	ate 20c. Loc	ation - City or Town, State	÷
1 X Burial 2 ☐ Cremation 3 X R 4 ☐ Donatton 5 ☐ Other (Specify)		vid Mem Gra	dns = 04/03	3/2012 Fal	ls Church, L	/A
21. Signature of Juneral Service Fice see		22. Name and Addre	ess of Facility HLNC	s-Rinardi F	uneral Home Spring,MD	, Inc.
23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the death. Do not cause on each line.	enter the mode of dyi	ng, such as cardiac or	respiratory arrest,		Between
Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):		bolism		Onset a	nd Death Minutes
Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequence of):					
resulting in death) Last	Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1	3 ☐ Ectopic pregnan 5 ☐ Other (specify) _	су	23	d. Date of delivery Month Day	Year
Part II. Other significant conditions conditions Coronary Artery	-	he underlying cause g	iven in Part I.		e contribute to the cause of	
				24a. Was an autopsy performed? 1 Yes 2 🗓 No	24b. Were autopsy findin prior to completion death? 1 Yes 2 No	gs available of cause of
25. Was case referred to medical examiner?		26. P	lace of Death (Check o	nnly one)		
1 ☐ Yes 2 💢 No	ospital: 1 Inpatient 2 ER/Outpa	atient 3 🗓 DOA Oth	ner: 4 Nursing Hom	e 5 Residence 6	Other (Specify)	
27. Manner of Death 1 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury 28b. Tim (Month, Day, Year) inju	ry wor		d. Describe how injury o	occurred	
4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28	Bf. Location (Street and I City or Town, State)	Number or Rural Route Nu	umber,
(Check 2 Medical Examine only one) 3 Certifying Nurse	clan: To the best of my knowledge, deer: On the basis of examination and/or in Practitioner: To the best of my knowle	vestigation, in my opini	on, death occurred at th	ne time, date and place, a	nd due to the cause(s) and	manner stated.
29b. Signature and title of contifier	been M.	29c. Licens D 2	e number 6540	29d. Date	signed (Month, Day, Year)	1 -

DHMH 17 Rev 06-2011

State Registrar Carl I.

5

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible and #8 Per ANA BD G926 4/17/2012 JH State of Maryland / Department of Health and Mental Hygiene 2012 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1558 P M Joseph L. Anthony 20/2 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Sinai 13al himore 1tospital If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Hours (Month, Day, Year 933 219-28-8510 1 XM 2 - F 79 20. Maryland Feb 1033 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1472 Holston Court 21076 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify. Specify: white 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) security guard food warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leo Anthony Gladis Willett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Cosgrove/sister P.O. Box 411 Cacapon. WV 25402 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) 21. Signa un oi Funeral Service ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director in Baltimore, MD 21201 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, at heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Premonia to ventilator Secondary dependen disease or condition resulting in death) Due to (or as a consequence of) Unknown COPD if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of) resulting in death) Last 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performe

Physician/ Medical Examiner

Known as Joseph Anthony

Physician/ Medical

Examiner

Funeral

Director

23a or 28a-f show

Director

Funeral

Completed by

Be

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 53a or 28a-f shown injury or other traumatic event, the Medical Examiner mist be notified at any injury or other traumatic event, the Medical Examiner mist be notified at once.

Baltimore, Maryland 21215-0036

Examine

and burial-tra the attending physician To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the for signed by has this certificate s after death. filled in by

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

	building, sto. (obcony)	City or Town, State)
29a. Certifier	1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the cause(s) and manner as stated.
(Check	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	
only one)	3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and p	lace, and due to the cause(s) and manner as stated.

29b.	Signa	ature and t	tle of certifier		_
		An	ilner.	Fran	

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

State

Medical

Certificate: To Be Completed by Physician/Medical

31. Date filed (Month, Day, Year) APR 1 9 2012 Registrar's Signa

Registrar

within 24 hours a

To the Funeral C

completely filled

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James W. Armacost April 2012 5:40 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore County Examiner 4b. City, Town, or Location of Death Upperco 17218 Pleasant Meadow Road If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. ocial Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 214-20-0583 Months (Month, Day, Year) Director 1 XM 2 □ F 86 Aug. 18, 1925 Maryland Usual Residence of Decedent show 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director Baltimore County Upperco Maryland 28a-f 1 Yes 2 No 5 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 21155 United States 17218 Pleasant Meadow Road ral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give white 3 Divorced "natural" Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) self-employed farmer agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, d Mental 2 George Wayson Armacost Willa Burnetta Armacost and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 17218 Pleasant Meadow Road Upperco, Maryland 21155 Elsie M. Armacost / wife Baltimore, 20a. Method of Disposition April 11 Department of H Important: If ite any injury or off once. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Upperco, Maryland Grace U.M. Cemetery 2012 Signature of Funeral Service Licens 22. Name and Address of Facility Eline Funeral Home M01072 934 South Main Street Hampstead, Maryland 21074 an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death Ph_sician/ Multiple Myeloma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): nding physician are as the burial Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year 2 No the Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ D.M., C.A.D., Afib. Division of Vital Records, 1 Yes 2 X No 3 Probably 4 Unknown Completed Were autopsy findings available 24a. Was an has page 2 prior to completion of cause of death? autopsy performed? Yes 2 No Director: After this certificate 1 Yes 2 No 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Hospita 2 🗶 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury hours after death. 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation
6 Could not be þ 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, within 24 hours a Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 E Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier aNIN 0051705 30. Name and address of poson who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

Maa

31. Date filed Month, Da

10 V

Malcolm

Dr. Westminster ND 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 20b, per fb, 9926 4-19-12 sm
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Brown Mia Physician /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 M 2 M 219-31-746 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** Kesville MD Bal permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nature"." any injury or other traumating energy. 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21208 46 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S Armed Forces? 12 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 NO 1 Yes 2 No Specify ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Educat 109 Elementary/Secondary (0-12) College (1-4 or 5+) S Tude 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Xon ည Kevin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Batto, Md 21208 mother 163 H-Brown 3 Grrie 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Mt center of creme tery 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address md 21229 mala 270 fred Hillon Pass, 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): **Physician** monall disease or condition resulting in death) /Medical **Examiner** Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and as the burial-trans Due to (or as a consequence of) Box 68760 Physician/Medical as IF FEMALE: nse 23b. Was decedent pregnant in the past 12 morans? 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Tectopic pregnancy in the past 12 months 1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) P.O. 9 Unknown the 9 Unknown by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Division of Vital Records, page 2 should be 2 No 3 Probably 4 🗌 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 Yes 2 🗌 No 2 No 1 ☐ Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medica Be Hospital: 1 Inpatient Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 Other (Specify) 1 🗌 Yes 2 12 No 2 ER/Outpatient 3 🗌 DOA ၉ this 28a. Date of Injury (Month, Day Year) 27. Manne of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Medical Certification: After Injury 5 Pending investigation in 24 hours after deam.

the Funeral Director; After a mind in by the fu 1 🗌 Yes 2 🗌 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 3 Suicide Could not be determined City or Town, State) 4 - Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title 2

State Registrar

31. Date filed (Month, Day, Year)

APR 1 9 2012

APR 2 9 2012

APR 3 2 Aegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

000

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ P^{M} 9:10 Robert Elmer Burman April Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Baltimore Maryland Masonic Home Cockeysville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours Dec. 13, Year 1926 Country) Maryland 1 XX M 2 D F 85 218-22-4046 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Baltimore Cockeysville 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number Funeral 300 International Cir. 21030 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Examiner Armed Forces? Black, White, etc. "natural", or by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 45'-46' White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) Baltimore Gas & life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) N/A other traumatic event, the Sr. Electric Test Man Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ pe Alvin H. Burman Christian E.H. Yingling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 21231 Edward K. Lumsden/Friend 411 S. Ann Street, Baltimore, MD 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 16 permit. Page 1 a Department of H Important: If ite any injury or ot Dufaney crematory or other place)
Memorial Gardens 2012 Timonium, MD 4 Donation 5 Other (Specify) Lemmon Funeral Home of Dulaney Valley, I 21. Signature of Funeral Service on see Michael 10 W. Padonia Road J. 23a. Part 1. Sater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congesti Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Cell that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director. After this certificate has leted filled in by the funeral director, page 2.9 autopsy performed? Yes 2 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The decision of the basis of examination almost introduction, it is specified at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

ROBENT

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MD. 32. Registrar's Signature LTG.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BENTO

12-02949			or Print in Bl								jible.		
Betty Blaney		Stat I- For State	e of Maryland		ιπment d tificate d			a Ment	аг пудк		7	201	2 1219
Physicia		Registrar 1. Decedent's Name (First, Middle,I	ast)	061	incate c	n Deal			2. D	ate of Deat	g. 140		3. Time of Death
Medical Examin	ı" ıer	Betty (nmn) Bla							A,	onth oril 15, 20	Day 012	Year	1515 hrs
F		4a. Facility Name (if not institution,						Location o			4c. Cou	inty of Death	1
		Upper Chesapeake Med				Bel A				- 45	Harfo		
Funeral		5. Social Security Number 6.		(in yrs. la	ast birthday)	If Und Month	er 1 Yea ns Day		Min.			Foreig	thplace (State or
Director		217 12 7710	M 2XF	88	Yı	rs.	1	17	įN	ov. 2	8, 192	23 6	ountry Maryland
ku a	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loca	ation							10d. Inside City Limits
		Maryland Harf	ord	Bel	Air								1 Yes 2 X No
arylan 8a-f s	Director	10e. Street and Number	014	202		10f. Zip	Code			10	g. Citizen o	f What Cou	ntry?
eath with the Maryland items 23a nr 28a-f show ust be notified at once.		987 Phillips P	lace			2	1014	1			USA		
n with	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.					in? (Specify Puerto Rica			Race - Ameri White, etc.	ican Indian, Black,
r deatl nr ite	티	1 Never Married 2 Marr	1 Yes 2	X No	_		_				Spec	ni6:: TATL	nite
rs afte ural",	[조	3 Widowed 4 Divord 15. Decedent's Education (Specification)	or Dates:	pleted)	16a. Decede	Yes 2			and of work	done		of Business/	
2 hou	E E	Elementary/Secondary (0-12)	College (1-4 or 5						use retired)				
215-0036 be filed within 7 ntal Hygiene. rked other than	Completed	12			Depu	ty Ch	ieÉ						vernment
5-0 lied w Hygie		17. Father's Name (First, Middle, La	•	•					s Name (Firs			,	
2121 2121 ould be fi Mental marked cevent,	B	Charles Archer 19a. Informant's Name/Relationship			19h Maili	na Address	S /Stree		h Fra				7 Zip Code)
MD 2 nd 2 shoul alth and N m 27 is m sumatic	의	Roberta Warfiel				-	•						21050
and 2 and 2 fealth fitem 2	_0	20a. Method of Disposition	·		Place of Disponentations	osition (Na	me of ce		Da				Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", ur items 23s nr 28s-f sho injury nr other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cremation 4 Donation 37 Other Spec	-	16	ly Cro			erv	4-18	- 12	Stre	eet, N	Maryland
mit. F		21. Signature of Vuneral Service Ci	censee						. Home				
E.E.S.S		Much CI V	mg			317 C	'okes	sburv	Road.	Abin	adon.	MD 21	Approximate Interval
Physician /Medical		23a. Part I. Enter the disease, or co failure. List only one cause or	n edich line				or ayıng	, such as ca	ardiac or res	piratory arre	sst, shock, o	i neart	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse			isease							Deali
` = ·		Sequentially list conditions,	b.	oquerioe o	.,.								- 1
	ē	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of	f):								
-	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of	f):								
tal Records, P.O. Box 68760, cian: The law requires that the death certificate be executed certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - transit	cal E	TATALON STREET	d										-
be exe ician a	diç	UNPENDED	AMENDED										
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor	ne of preg		Fetal death	3	Ectopic	pregnancy		23d. Dat Mon	ite of deliver ith	y Day Year
x 68 h certi tendin	Ciar	past 12 months?	4 Pregnant at	time of de		Other (Spe			,		1		
Bo e deatl	hys	1 Yes 2 No 9 Unkn	9 Unknown	_					1	ODa Did to	thacea was a		the cause of death?
Division of Vital Records, P.O. rai or Attending Physician: The law requires that th rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ΡP	Part II. Other significant conditio	ns contributing to deat	n but not re	esulting in the	underlyin	g cause	given in Pa	IT, I.	_	-		bably 4 V Unknown
quires	pe									24a. Was	an 2	4b. Were a	utopsy findings available
Orc law re has be 2 shor	Completed									autop perfo	sy med?	prior to death?	completion of cause of
Rec The ficate page	Sol						OC Disc	a of Dooth	(Check only		2 🗸 No	1 Y	es 2 No
ician:	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	ent 2 🗸	ER/Outpatie	ent 3 1	DOA	Other ₄	Nursing Ho		Residence	6 Othe	
of V g Phy fter thi	<u>1</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ıry	28b. Time a		28c. Inju	ury at Work	? 28d	. Describe	now injury o	ccurred	
OD cendin	tion	1 Natural 5 Pendir 2 Accident Investi		ear)			1	Yes 2	No				
ViSi or Att fifter de Direct in by	ifice	3 Suicide 6 Could	not be 28e. Place of In	jury - At h	ome, farm, st	reet, factor	y, office	building, et	c. 28f.	Location (S		lumber or R	ural Route Number, City
Dj spital nours a neral)	Certification:	4 Homicide determ	1-777	_									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of miner:On the basis of exa	y knowled mination a	ige, death occ and/or investig	curred at th gation, in m	ie time, c ny opinio	fate and pla n, death oc	ace, and due curred at the	to the caus time, date	e(s) and ma and place, a	inner as stat and due to ti	ted. he cause(s)
To t with To t	Medical	29b. Signature and title of certifier	and manner stated.					se number	_				onth, Day, Year)
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, —		eo Name and address of person w		leath (lien		,							
4		Theodore M. King, Jr.,	m w 1 1					more Str	eet, Baltir	more, Mi	21223		
St Regist	ate	31. Date filed (Month, Day, Year)	2012 32. Jegistra	ir's Signati	Ure S	enter	,						
Regist	Tel.	MEN 4 3	AAIR INGA		7								

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		4	State of M	aryland / Depa	artment of H			201	2 12192
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	uncate of D	eatti	2. Date of Death	9. Ho.	3. Time of Death
	Physicia Medic	n/	Susie M. Bert					5, ^{Day} 2012 Year	3:20 pm ^M
garde.	Examin		4a. Facility Name (if not institution, give street and number)			Location of Death		4c. County of Death	
and the second	Francis		Ridgeway Manor Nursing & 5. Social Security Number 6. Sex 7. Ag	Rehab ge (In yrs. last birthday)	Catons If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Baltimore 9. Birt	hplace (State or Foreign
	Funeral Director		200-32-8362 1 □ M 2 □ XF	76 Yrs.	Months Days	Hours Min.	Feb. 16	, 1936 Ala	oama
	how at	Ž	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	// Aarylar 8a-f s tified	recto	MD Baltimore	Owings	Mills				1 Yes 2XXNo
	ith the N 23a or 2 st be no	Funeral Director	10e. Street and Number 11035 Mill Centre Drive	•	10f. Zip Code 21117	7	1	0g. Citizen of What Co USA	untry?
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give	₹No	Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 🕱 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: B1:	e, etc.
21215-0036	in 72 hours e. nan "natura Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or	(Give 5+)	dent's Usual Occupa kind of work done d O NOT use retired)	luring most of work		16b. Kind of Business Chemical	•
121	d with Hygien ther th	Be C	12. Father's Name (First, Middle, Last)	Help	er-Prod.		e (First, Middle, M		Company
land	l be file lental l rked o ric eve	일	John Harrell			Inez R			
Maryland	should and N is ma rauma		19a. Informant's Name/Relationship (Type, Print)					City or Town, State, Zip	Code) 21117
e, N	and 2 Health tem 2;		Vivian Bert - Daughter 20a. Method of Disposition	20h Place of Dispo	sition (Name of	!		Mills, MD 20c. Location - City or	
mol	Page 1 nent of ant: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Round Hi Cemetery	matery or other plac	; 4-41	-2012	Elizabeth	
Baltimore,	permit. Departrimporta any inju		21. Signature of Funeral Service bicensee		2. Name and Addres			tan Funera ria, VA 2	
	Physician/		Sa fart Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lir Immediate Cause (Final disease or condition	ed the death. Do not ent ne.	er the mode of dying $d\ell M\ell n$	g, such as cardiac Ha	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death) Due to (or a	a consequence of):					V
		iner	Sequentially list conditions, if a ry, leading to immediate cause. Enter Underlying Cause (Disease or linjury	a consequence of):					
	be executed sician and burial-transit	Examiner	that initiated events C	a consequence of):	 	<u> </u>			
09	te be exi	dical E	d						
876	tificate ng phys as the	Med	IF FEMALE:						
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant 1 Live Birth	2 Fetal death 3 at time of death 5	☐ Ectopic pregnand ☐ Other (specify)	су		23d. Date of de Month	livery Day Year
ls, P.O.	v requires that the de sbeen signed by the should be detached		Part II. Other significant conditions contributing to death Hypartense for the conditions contributing to death	but not resulting in the	underlying cause giv	ven in Part I.		es 2 No 3 P	the cause of death?
Records,	The law rectate has been page 2 sho	Completed by	Psychasis				24a. Was ar autops perforr 1 \(\sum \text{Yes} \)	prior to death?	topsy findings available completion of cause of
ital	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpa		Oth	er: Chec		0 D Other (Case)	
of V	ng Phys fter this ineral di	ate: To	27. Manner of Death 1 Natural 5 Pending	tient 2 ER/Outpatie jury 28b. Time o injury	f 28c. Injur	y at		ence 6 Other (Spec w injury occurred	<u>.</u>
Division of Vital	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Variable 4 Could not be 28e. Place of Ir	njury - At home, farm, st etc. (Specify)		Yes 2 No	28f. Location (St. City or Town	reet and Number or Ru n, State)	ral Route Number,
Ω	lospital t hours uneral ed filled	dical	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of	examination and/or inve-	stigation, in my opinic	on, death occurred a	at the time, date an	d place, and due to the	cause(s) and manner stated
	ithin 24 o the F	Me	only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier	e best of my knowledge,	death occurred at th	e time, date and pla	ice, and due to the	cause(s) and manner as	stated.
	FSFÖ		· Creetna Reya Ms		Da7	541	/	19d. Date signed (Mont April 16) New MJ	2012
2			30. Name and address of person who completed cause of CEETHA RASA IMD, L			y Rd,	Baltin	rone, MD	21227
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 9 2012	trar's Signatur	arke				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Henrietta Butcher 0012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore HOSP.700 Saint If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🛣 F **Director** 280-16-2096 09-12-1917 Ohio Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Catonsville 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane, #420 21228 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Homer Powers Gussie Huddle မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William W. Butcher/Son 8240 Frances Lane, Owings, MD 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Atlantic Crematory 04/15/2012 Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Mule 1630 Edmondson Ave., Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dravdiai **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that in its land assets. Examiner Due to for sels, consequence off that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ NO Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 | Yes 2 | No 3 | Probably 4 | Johnnown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was a... autopsy performed? Yes 2 1□ Yes Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier (Check only one) 1 👱 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) KUBIEWOLL MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Baltimore Ces twoid 900 31. Date filed (Month, Day, -Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 4 Physician/ 1226 BROOKS 9 M MILLIAM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE Grand BURNIE AHNE ARUNDEL WASH IN LTO N 03 CTK Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex **Funeral** Min 219-28-6017 **Director** 1 🛛 M 2 🗆 F 03/24/1933 MD 79 Usual Residence of Decedent 28a-f show with the Maryland aţ 10a, State 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Tes 2XXNo MD Anne Arundel Glen Burnie 10e. Street and Number 10f, Zip Code ò 10g. Citizen of What Country? must be n Funeral 1616 Pleasantville Drive 21061 U.S.A. items ; death tal Hygiene. ad other than "natural", or items event, the Medical Examiner m Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Engineering Draftsman Baltimore City event, Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ည William Brooks Victoria Zabrowski other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trai Mrs. Rosina Brooks / wife 1616 Pleasantville Dr, Glen Burnie, MD 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 □ Donation 5XXOther (Specify) entombmen 4/19/2012 Loudon Park Cem. Baltimore, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD M01357 Singleton Funeral & Cremation Services, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ えてるとる disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician are as the burial Physician/Medical that the death certificate be use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at Id be detached for g 🗌 Unknown þ Medical Certificate: To Be Completed

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires to thours after death.
24 hours after death.
Funeral Director. After this certificate has been signiferely filled in by the funeral director, page 2 should be

Part II. Other significant conditions of	contributing to death but not re	esulting in the underlying	g cause given in Part i.		se contribute to the cause of death? No 3 Probably 4 X Unknown
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No
25. Was case referred to medical			26. Place of Death (Che	ck only one)	
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing I	lome 5 ☐ Residence 6	Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
3 Suicide 6 Could not be 4 Homicide determined	1280 Place of Injury - At		ory, office	28f. Location (Street and City or Town, State)	l Number or Rural Route Number,
29a. Certifier 1 Certifying Phy	ysician: To the best of my kno	wledge, death occurred	at the time, date and place,	and due to the cause(s) ar	nd manner as stated.

To the Within 2 To the State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

D64307

GLEN BURNIE

MD

29d. Date signed (Month, Day, Year) 2012

20161

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

BUND VITBERL HOSPITAL DANGE

Year)

only one) 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2012 April Physician/ ar VID 8 13 7:14 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Waldorf Waldorf Genesis Health Center If Under 1 Year If Under 24 Hrs.

Davs Hours Min. 8. Date of Birth Nov • 12, 1950 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ★ M 2 □ F Months Virginia **Director** 223-72-4057 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State Director notified 1 X Yes 2 No Waldorf MD Charles 10f. Zip Code 10e Street and Number 10g Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 20603 USA 5921 Puffer Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☒ Yes 2 ☐ No 1969þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black If Yes Give Specify: 1973 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Store Manager Retail æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Christopher Clark Rena Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Waldorf, MD Teresa Clark - Wife Puffer Ct., 20603 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Greenlawn Memorial 4 ☐ Donation 5 ☐ Other (Specify) awn Memorial | 04-19-2012 | Chesapeake, VA | 22. Name and Address of Facility Metropolitan Funeral Service 04-19-2012 of Funeral Service Licensee 5517 Vine Street, Alexandria, VA Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death rren mediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death ed by the a detached f 9 Unknown Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 X Natural injury 5 Pending 2 🗌 No Investigation Accident 24 hours after deat Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number Prily, 6934 Aviation Blud SteB, Glen Busnie, MD 30. Name and address of person who com 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

2012 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 12 Day 2012 Year George Clark 1715 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Montgomery Silver Spring Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Hours (Month, Day, Year) 227-66-9782 **Director** 1 🖾 M 2 🗌 F 64 Yrs Aug 11, 1947 Virginia Usual Residence of Decedent 28a-f shov at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD Silver Spring 1X Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 'n 10g. Citizen of What Country? by Funeral 23a8811 Colesville Road Apt. 803 20910 USA ral", or items 2 Examiner mus death Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Leventi, Page 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Importment if I tem 27 is marked other than "nature" any injury or other traumatic power. Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Asst. Manager Safe-Way Stores Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jessie Clark, Jr. Eva Oakes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loren M. Clark Daughter 2500 18th St. NE Washington, DC 20018 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Greater Triumph Miss 4-21-2012
Bapt. Church Cem.
22. Name and Address of Facility Metrop 4 ☐ Donation 5 ☐ Other (Specify) Signatura of Funeral Service Licensee Metropolitan Funeral Service 5517 Vine Street Alexandria, VA 22310 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Respiratory Failure Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of the burial-transi and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy been signed by the atter should be detached for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available 24a. Was an page 2 s After this certificate has autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 🔀 No Hospital Other: ျှ 1 Tes 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural
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3 Suicide
4 Homicide М Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29b. Signature and title of certifie 29c. License number

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

62. Registrar's Sign

Yeheyis Negussie, M. D.

APR 1 9 2012

31. Date filed (Month, Day, Year)

D45471

1111 Spring St. Ste 214, Silver Spring, MD

April 13, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2350 M Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** N/A General 10R4/and 8. Daye of Birth Birthplace (State or Foreign Country) Securit Number 6. Sex Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** (Month, Day, Year) Months Hours Min 217-58-1864 1 🗆 M 2 🗶 F Director Yrs 07/15/1950 61 MARYLAND Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location the Maryland Director 1 X Yes 2 □ No BALTIMORE MD N/A 10g. Citizen of What Country? 10f. Zip Code ō 10e. Street and Number pe 23a Funeral must | 21217 U.S.A. 2601 MADISON AVENUE, APT. 2810 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. "natural", or iter Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: WHITE 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) DOMESTIC HOUSEWIFE 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည CLARA BEAUMONT HENRY C. KELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21074 4915 MILLERS STATION RD., HAMPSTEAD, MD ANTHONY CRABTREE/ 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place) BAYVIEW CREMATORY 4/17/12 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
LJTLY EASTERN AVENUE, BALTIMORE, MD Signature of Fun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death povolemic Immediate Cause (Final Physician/ minues disease or condition Medical resulting in death) Du o (or as a consequence of **Examiner** sanguinatio Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Passive Hemarrhage Exami requires that the death certificate be executed and I-tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day the g Unknown P.O. I is signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy has page 2 1 🗆 Yes 2 🗹 certificate Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 \square No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this funeral 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: or Attending 1 Natural 5 Pending 1 Tes 2 No death. Μ Accident Investigation 6 Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined after within 24 hours af

To the Funeral D

completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar D

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JRINIVASAN, MD

Registrar's Signature

onth, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 04 2012 Dora Cooper 4:27 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Fairfield Nursing & Rehab Center Crownsville 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Hours 212-44-6234 **Director** 1 □ M 2 🗓 F 08/12/1945 VA 66 ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 100 Midfield Road South 21090 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 72 hours after Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify. White "natural", Specify: 3 ₩ Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Johns Eva Μ. Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tran 100 Midfield Road South Mr. Frank Johns / Brother Linthicum, MD 21090 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 04/20/2012 Glen Burnie, MD 22. Name and Address of Facility 1 2nd Avenue SW M01479 Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) emen Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit and that initiated events resulting in death) Last physician Physician/Medical requires that the death certificate be Box 68760 the as 1 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death the 9 Unknown Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 No prior to completion of cause of death? has certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Director: After 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0040519 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M NUCAIREE M.D. 1401 MAPISON PARK SUITE 100 CLEN BURNIE MD 20061 31. Date filed (Morith, Day, Year) State

HMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fh 9926 4-19-12 vt. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201^{ea}2 1:20 P M 13 COLE APRIL **GWEN** Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE BALTIMORE COURTLAND GARDENS If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Funeral (Month, Day, Year) Country) Director 219-05-9726 1 □ M 2 **X** F 90 05/15/1921 PA Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Examiner must be notified at Director 1 X Yes 2 No MD N/ABALTIMORE 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? 23a Funeral 5833 PARK HEIGHTS AVENUE, #211 21215 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 0 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: nan "natural", o If Yes, Give Year or Dates Specify: 3 X Widowed 4 ☐ Divorced Completed WHITE Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the BOOKKEEPER DRUG STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CAPLAN other traumatic FRANK MARY DANOFF 7058 Kamilo Street and Number or Rural Route Number, City or Town, State, Zip Code)
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1058 19a. Informant's Name/Relationship (Type, Print) If item 27 LOIS SHORE / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ţ, CHIZUK AMUNO CONG. permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Page . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final failure Pnysician/ to thove omosth disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner SOUD O years Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the at d be detached for Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 Jas page 2 certificate 25. Was case referred to medical To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral (27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death. Certificate: X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kathleen I. Louzon MS CRNP, 6503 Park Height Ave Baltimer MD, 21215

MS CRN

gistrar's Signatu

ron

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Month Physician/ 072 HON(35 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** Medica MINIQ 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 868 Hours Director 1 ☑ M 2 ☐ F 67 orea 28a-f shov 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No ANNE Arunde evern 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö must be by Funeral 23a ర 2/0 U.S.A INQ Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ō 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify If Yes, Give "natural", ISIAN 3 Widowed 4 Divorced Completed Year or Dates of Health and Mental Hygiene.
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Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day Month Pregnant at time of death Other (specify) 1 Yes 2 g Unknown Yes 2 No this certificate has been signed by the a ral director, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ္ဝ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director; Al М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed, (Month, Day, Year) mo 5652 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210 my -ONL 31. Date filed (Month, Day, Year) 32. State 2012 9

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	for State Of IVIS	ortificate (rntai mygieni Reg. N	2012 122111
	Physicia	_	Decedent's Name (First, Middle, Last) RETT	LOU CHANESK			3. Time of Death
4	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Tov	wn, or Location of Death		c. County of Death Talbot
1	Funeral		5. Social Security Number 6. Sex 7. Age	yrs. last birthday) If Under 1		Date of Birth	Birthplace (State or Foreign
	Director		216 48 7649 1 □ M 2 X F Usual Residence of Decedent	65 Yrs.	1	1 26 19	46 Maryland
	aryland a-f sho fied at	ector	10a. State 10b. County MD Caroline	Greensboro			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the Ma a or 28 be noti	Funeral Director	10e. Street and Number	10f. Zip Co		10g. C	Citizen of What Country?
	ath with	uner	307 Mallard Drive 11. Marital Status 12. Was Decedent 8	in U.S. 13. Was Decedent	21639 t of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ric	y Yes or No-	U.S.A. 14. Race - American Indian,
T.C. C.	filed within 72 hours after death with the Maryland tall Hygiene. The Maryland tall Hygiene and other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 🗷 Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 🗷 If Yes, Give Year or Dates.		Cuban, Mexican, Puerto Ric	an, etc.)	Black, White, etc. Specify: White
Bett	72 hour	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual C (Give kind of work of life. DO NOT use re	lone during most of working	16b.	Kind of Business/Industry
7 5	ygiene. ygiene. her tha	Be Cor	Elementary/Secondary (0-12) College (1-4 or 5	Homemake	er		wn Home
Maryland	Mental Hygnaric event,	To B	17. Father's Name (First, Middle, Last) Rober	Williams	18. Mother's Name (F Marie	First, Middle, Maidei	n Surname)
200	should be fil and Mental is marked raumatic ev		19a. Informant's Name/Relationship (Type, Print)		treet and Number or Rural R		
_			Daniel Chaneski - Husba 20a. Method of Disposition	20b. Place of Disposition (Name	of Date	ensboro	, MD 21639 Location - City or Town, State
Cha	Page nent o ant: If ury or		1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crematory or othe Glen Haven Me	em Pk 4/17,		en Burnie, MD
a c	permit. Departn Importa any inju		21. Signature of Funeral Sovice Licensee		Address of Facility GJ (viera Drive		uneral Home, PA dena, MD_ 21122
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final			espiratory arrest,	Approximate Interval Between Onset and Death
(Medical		disease or condition resulting in death) Due to (or as a	onsequence of):	·cercia		
	Examiner	er	Sequentially list conditions if any, leading to immediate b.	onsequence of):			
-	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c				
	cate be executed physician and s the burial-transit	edical E	resulting in death) Last Due to (or as a	onsequence of):			
68760	- 0 _ 0	/Medi	IF FEMALE:				
2	re death ce the attend	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	🗌 Fetal death 🛮 3 🔲 Ectopic pre			23d. Date of delivery Month Day Year
0	uires that the signed by ald be deta	þ	Part II. Other significant conditions contributing to death b	not resulting in the underlying cau	ise given in Part I.		ouse contribute to the cause of death?
Division of Vital Becords	To the Hospital or Attending Physician; The law requires that the death certification 24 hours after death certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
- c	sician; 1 certifica irector, 1	Be	25. Was case referred to the dical examiner? 1 Yes 2 No Hospital:		26. Place of Death (Check or Other:		
) of V	ding Phys th. After this	cate: To	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation	2 ER/Outpatient 3 DOA 28b. Time of injury M 28c.	·	e 5 ∐ Residence d. Describe how inju	6 ☐ Other (Specify) ury occurred
ivieio	al or Attending P a after death. I Director: After the	Certificate:	2 Suicide 6 Could not be	At home, farm, street, factory, o	ffice 28	f. Location (Street a City or Town, Stat	and Number or Rural Route Number, te)
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of only one) 3 Certifying Nurse Practitioner: To the	nination and/or investigation, in my	opinion, death occurred at the	e time, date and plac	ce, and due to the cause(s) and manner stated.
	To the within compare compare the compare	-	29b. Signature and title of certifier RMohoun	29c. L	icense number		Date signed (Month, Day, Year)
/			30. Name and address of person who completed cause of d	(Item 23a) (Type Print)		- 17/27	10,11,000
9	Stat	0	R. Molton M.D. 2/9 31. Date filed (Month, Day, Year) 32 Residen	5. WASIHIN	GTON ST E.	ASTON	MD 21601
1/	Registra		APR 1 9 2012 / 2014	1. back			

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State of Maryland / Department of Health and Mental Hygiene	2012	1

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			for State Registrar	State of Marylar	id / Deba	tificate of D	lealth and	ivi c niai riyç	Reg. No.	
Ì	Physicia		Decedent's Name (First, Middle, Last)	HARRIET				2. Date of Dea	th	3. Time of Death 10:52 P M
	Medic Examin		4a. Facility Name (if not institution, give stre		3.1127112	4b. City, Town, or		1	T	y of Death
	<u></u>	ш	8310 Tyndswall I 5. Social Security Number 6. Sex	Place 7. Age (In yrs. i	last hirthday)	Pasade	ena If Under 24 Hrs	9 Date of Birth		e Arundel
	Funeral Director		040 70 0406	1. Age (in yrs. i	Yrs.	Months Days	Hours Min.	(Month, Day	; Year)	Birthplace (State or Foreign Country)
	, MC		Usual Residence of Decedent	73		<u> </u>		01 13	1939	Maryland
	a-f sh	Director	10a. State 10b. County MD Anne Aru		ty, Town or Loc Asaden					10d. Inside City Limits 1 ☐ Yes 2 🄀 No
	the Ma or 28	ä	10e. Street and Number	nder ra	isaueii	10f. Zip Code		T	10g. Citizen of	What Country?
	s 23a	Funeral	8310 Tyndswall I	Place			21122		U.	S.A.
	r death r item iner n		11. Marital Status 12 1 Never Married 2 Married	Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ce - American Indian, ack, White, etc.
920	rs afte	ed by	3 Widowed 4 □ Divorced	1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates.	1	☐ Yes 2 🗷 No	Specify:		Specify	White
21215-0036	is filed within 72 hours after death with the Maryland tal Hygiene. Id altygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Educa (Specify only highest grade of		(Give I	lent's Usual Occupa kind of work done di	ation uring most of wo	rking	16b. Kind of E	Business/Industry
121	ithin 7 iene. r than the M	Com	Elementary/Secondary (0-12)	College (1-4 or 5+)		onoruse retired) ntory M	anager		Picky	vick, Inc.
ק סר	be filed wit lental Hygie rked other ic event, th	Be	17. Father's Name (First, Middle, Last)		11170	liboly in		me (First, Middle, i		
Maryland	should be file and Mental I is marked o raumatic eve	은		ack Harold	l Turl	ey	Mildre	ed Henr	ietta	Armiger
Mai	of Health and Ments of Health and Ments fitem 27 is marked rother traumatic e		19a. Informant's Name/Relationship (Type, Sandy Atwood - D		4	ng Address (Street a Tyndswa				
e,	1 and of Heal item		20a. Method of Disposition	20b. i	Place of Dispo	sition (Name of natory or other place	- 1	Date		- City or Town, State
Baltımore,	<u> </u>		1 ☐ Burial 2 🗷 Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)					16/12	Balti	more, MD
Balt	permit. Pag Departmen Important: any injury once.		21. Signature of Finer ryice Licensee		22	Name and Addres	s of Facility G	J Gonce	Funer	ral Home, PA a. MD 21122
			23a. Part 1. Enter the disease, or complica	tions that caused the deat	th. Do not ente	69 Rivi	, such as cardiac	or respiratory arm		Approximate
a	Physician/		shock, or heart failure. List only one c Immediate Cause (Final disease or condition	Metastat	ic Br	east C	ancer			Interval Between Onset and Death Vears
· A	Medical Examiner		resulting in death)	ause on each line. Mefastat Due to (or as a conseq Brain	uence of):	antone (3 months
4	1	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq		on arcs				37100117005
	executed an and rial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events c							
	be executed sician and burial-transit	<u></u>	resulting in death) Last	Due to (or as a conseq	uence of):					
09/89	requires that the death certificate be exe been signed by the attending physician should be detached for use as the burial	Physician/Medic	d							
ž ×	th certi tendin or use	ian/	23b. Was decedent pregnant	If yes, outcome of pregna	al death 3		y			ate of delivery
. Box	the atter	ysic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5∟	Other (specify)			IVI	onth Day Year
J.	that the ned by e detai	by Pr	Part II. Other significant conditions contri	buting to death but not res	sulting in the u	nderlying cause give	en in Part I.			tribute to the cause of death?
ďs,	equires sen sig ould b	ted						1 🗆 ነ	es 2 No	3 Probably 4 Unknown
Vital Records,	has be ge 2 sh	Completed						24a. Was a autop perfor	sy	Were autopsy findings available prior to completion of cause of death?
ř	an: The ificate tor, pag	Be Co	25. Was case referred to medical			26. Pla	ace of Death (Che	1 \(\text{Yes}	2 No	1 Yes 2 No
VIta	nysicia nis cerl I direct	To B	examiner? 1 Yes 2 No	pital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	Othe		Home 5 Resid	ence 6 🗆 Oth	ner (Specify)
וס ר	ling PI After th funera		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work?	?	28d. Describe he	ow injury occur	red
Division of	Attenc r death ector: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he			Yes 2 No	28f. Location (S	treet and Numb	per or Rural Route Number,
<u>≥</u>	tal or irs afte al Dire	Ce		building, etc. (Specif				City or Tow	,	
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	edical	(Check 2 \(\sum \) Medical Examiner:		n and/or invest	igation, in my opinio	n, death occurred	at the time, date ar	nd place, and du	ue to the cause(s) and manner stated.
	To the within To the comple	Σ	29b. Signature and title of certifier	ractitioner: To the best of		29c. License	number		29d. Date signe	ed (Month, Day, Year)
			> mues	M.D.		D5	74413		APR	.16,2012
			30. Name and address of person who compounds J. Lee.	oleted cause of death (Item	23a) (Type, P	er st.	Baltin	nore	MD	21225
	Sta		31. Date filed (Moral PR 19 2012	37 Registrar's Signa	1 L	iles				
	Registra	ar		Market 1	- CF"	_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 19b, 20b, 22 per fh. g926 4-19-12 vt. 21 copies Are Legible. 2 0 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10 pay Physician/ 2012 9.00 AM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Baltimore 1907Boone Street 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** PA Country) 1 🛛 M 2 □ F Hours 0 \$77637 1955 57 Director 191-44-6890 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Examiner must be notified 1 Yes 2 No N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö items 23a U.S.A. 1907 Boone St. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian. 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. à 1 X Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 Divorced 4 Divorced U.S.A. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Contractor Self unk injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Johnnie M. Owens Lewis Covington 19a. Informant's Name/Relationship (Type, Print) Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 450 Gray St., Elmira, N.Y. Joseph B. Covington (20b. Place of Disposition (Name of cemetery, crematory of other place, 20a. Method of Disposition Date 20c Location - City or Town, State 1 🔲 Burial 2 Cremation 3 🗆 Removal from State 04/16/12 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Dervice Licens Williams 22. Name and Address of Eacility Joseph H. Brown Jr 7140 N. Partion 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause/Final Approximate Interval Between Onset and Death Priysician/ MYUCANDIAL disease or condition resulting in death) Medical Examiner Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Hyperlipiden been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a cons Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by END- STACE KIDNIG 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be | examiner? Other: 4 Nursing Home 1 🗌 Yes Certificate: To 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours after death. e Funeral Director: Af pleted filled in by the fu Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year, 9 2012 Registrar

ANTHING

29b, Signature and title of certifie

KM

30. Name and address of person who condeted cause of death (Item 23a) (Type, Print)

Registrar's Sign

29d. Date signed (Month, Day, Year)

But MD

W. BMIT ST,

		-	State	epartment of Health and M Certificate of Death	2012 122114
			Registrar 1. Decedent's Name (First, Middle, Last)	Sertificate of Beatif	Date of Death 3. Time of Death
	Physicia Medic		Phyllis Margaret Davis		April 11, 2012 4:10 AMM
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death Baltimore
	Funeval		Gilchrist Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birth)	Towson If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9. Birthplace (State or Foreign
	Funeral Director		215 27 7222	Months Days Hours Min.	(Month, Day, Year) Country) June 2, 1922 England
	d d		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
	arylan a-f sh fied a	Director		ltimore	1 ☐ Yes 2 😾 No
	or 28	Dir	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	s 23a	Funeral	511 Regester Avenue	21212	USA
	death r item iner n		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 	cify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.
036	s after al", o Exam	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ♣ No 3 🛣 Wildowed 4 ☐ Divorced Year or Dates.	1 ☐ Yes 2 🛣 No Specify:	Specify: white
2-0	natul	Completed	15. Decedent's Education 16a. [(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of work	16b. Kind of Business/Industry
121	thin 72 ane. than he Me	Som	Elementary/Secondary (0-12) College (1-4 or 5+)	fe. DO NOT use retired)	
d 2	led wi Hygie other ent, tl	Be (8 0	crossing guard 18. Mother's Nam	school system e (First, Middle, Maiden Surname)
/lan	d be fi Mental arked rtic ev	P	Edwin Morris	Anne l	Morris
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ā		Mailing Address (Street and Number or Rura 107 St. Albans Way Ba	al Route Number, City or Town, State, Zip Code)
e,	and 2 Healtl tem 2	- 8			Date 20c. Location - City or Town, State
mol	age 1 lent of nt: If i			, crematory or other place)	
alti	permit. F Departm Importa any inju		21. Signature Funeral Service Lionsee Director	28 Name and Addrase of East lity Boar	d 655 W. Baltimore Street
<u>m</u>	20 5 6 9		23a. Part 1. Enter the disease, or complications that caused the death. Do no	Baltimore, MD 212	
	Medical Examiner	iner	shock, or heart failure. List only one cause on each line.	uler :-	Interval Between Onset and Death
092	icate be executed physician and is the burial-transit	ledical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C. Due to (or as a consequence of d.):	
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicately filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)	23d. Date of delivery Month Day Year
ds, P.O.	quires that t en signed b ould be deta	by	Part II. Other significant conditions contributing to death but not resulting in Biliary Stricture	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records,	To the Hospital or Attending Physician: The law re within 24 hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sh	Completed			24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
ital	sician; certifi irector	Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Out	26. Place of Death (Chec	. 1/ 1 .
of V	ding Phys h. After this funeral d	e: To	27. Manner of Death 28a. Date of injury 28b. Ti	me of 28c. Injury at	ome 5 Residence 6 Other (Specify) HOSPICE 28d. Describe how injury occurred
on (ending eath. ir: Afte	ficat	2 Accident Investigation	jury work? M 1 🗆 Yes 2 🗆 No	
Visi	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	m, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Ω	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	Medical (29a. Certifier 1 & Certifying Physician: To the best of my knowledge, d	leath occurred at the time, date and place, a	nd due to the cause(s) and manner as stated. t the time, date and place, and due to the cause(s) and manner stated.
	the Ho hin 24 the Fu	Med	only one) 3 Certifying Nurse Practitioner: To the best of my know	ledge, death occurred at the time, date and pl	ace, and due to the cause(s) and manner as stated.
_	vii V		29b. Signature and title of pertifier Which is the property of the property of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifier of the pertifi	29c. License number D72139	29d. Date signed (Month, Day, Year) Above 8 1/15 2012
					altimore MD 21204.
	Sta		31. Date filed (Month, Day, Year) APR 1 9 2012 31. Registrar's Signature	backer	
	Registr	ar	HELT A COLC TOPONO 10.		

		-	For State	State of N	/laryland		artment o tificate o			∕lental Hy		201	2	1220	5
	_		Registrar 1. Decedent's Name (First, Middle, L	act)		Cer	uncate o	Deau	1	2. Date of De		201		3. Time of Death	ĭ
	Physicia		Lawr	ence Dan	N. S					Month April	Day	Zo 17	r	9', 55 M	
	Medic Examin		4a. Facility Name (if not institution, gi				4b. City, Tow	n, or Locatio	on of Death			ounty of De	eath		٦
J			Seasons Hospice	e/NW Hospi	tal		Rand	allsto	own			Balt:	imor	·e	
	Funeral Director		219-22-9391	Sex 7. A 1 🔀 M 2 □ F	ge (In yrs. lasi 84	t birthday) Yrs.	If Under 1 Ye Months Da		der 24 Hrs. s Min.	8. Date of Bir (Month, Da Apr 30	th y, Year) 1927	9. I	Birthpla Co <i>untry</i> a ry I	ce (State or Foreign) .and	
	ind ihow at	5	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation						100	I. Inside City Limits	٦
	Aaryla 8a-f s tified	Funeral Director	MD Baltin	nore		Owing	gs Mill	S						1 🗋 Yes 2 🙀 No	
	the Na or 2		10e. Street and Number	NOT C	-	0 11 1117	10f. Zip Coo				10g. Citize	n of What	Country	?	
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980	12 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show r traumatic event, the Medical Examiner must be notified at	d by Fu	 11. Marital Status 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced 	12. Was Decedent Armed Forces 1 X Yes 2 If Yes, Give Year or Dates.	? No	1	Vas Decedent of Yes, specify C			ecify Yes or No- Rican, etc.)		. Race - Ar Black, Wl ecify:			
Ŏ	hours natur dical I	Completed	15. Decedent's	Education	75-40	16a. Deced	lent's Usual Oc		ost of work	ing	16b. Kind	of Busine	ss/Indu	stry	Т
21	nin 72 ne. :han "	E O	(Specify only highest Elementary/Secondary (0-12)	College (1-4 or		life. Do	O NOT use reti	red)	iost of work	my					
2	d with	Be C	12 17. Father's Name (First, Middle, Las		5+	sur	perviso		athor's Nom	ne (First, Middle,	Maidan Su	SSA			_
ylanc	ild be file Mental I larked o latic eve	10	Lawrence Sar	,	s Sr				Mary	McDono	ıgh				
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☒ Donation 5 ☐ Other (Sp)	Removal from State			sition (Name or natory or other			Date	20c. Loca	ation - City	or Tow	n, State	
Balt	permit. Departr Imports any inji		21. Signatur of Funeral Service co	ens Waha	rector	- 3t	Name and Acate An	atomy	Board Board	1,655 W	. Balt	imore	e St	reet	
	Ph_sician/	20	23a. Part 1. Inter the disease, or co shock, o'Neart failure. List only Immediate Cause (Final	rone cause on each li	ne	Do not ente		dying, such			rest,		- In	approximate nterval Between Onset and Death	
	Medical Examiner		disease or condition resulting in death)	a	s a conseque										-
	sit q	Examiner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying	b. Due to (or a	s a conseque	ence of):									_
	e execute cian and vurial-tran	al Exar	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	s a conseque	nce of):							+		_
760	ate b physic the b	edical		d											_
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live Birth 4 ☐ Pregnant g ☐ Unknown	n 2 ☐ Fetal∈ tat time of de	death 3	Ectopic pregl Other (specif				23	d. Date of Month		ay Year	
, P.O.	es that the	by	Part II. Other significant conditions	s contributing to death	but not resul	Iting in the u	nderlying caus	e given in P	art I.			_		cause of death?	
rds	requir been s should	etec								24a. Was				y findings available	_
Reco	The law cate has by page 2 s	Completed								auto perfe		prior death	to com	oletion of cause of	
ta	cian: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				6. Place of Dother:				110-0	4 Die	at healding	_
<u> </u>	Physi this c ral dir	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpa	atient 2 E	R/Outpatier 28b. Time of	nt 3 🗆 DOA		Nursing H				ecity)	nt hospice	
o uo	ending l sath. or: After the funer	Certificate:	1 Natural 5 Pending 2 Accident Investigat	(Month, E		injury	1-33.	njury at work? 1 ☐ Yes 2	! □ No	28d. Describe	now injury o	ccurrea			
Division of Vital Records,	tal or Att rs after d al Direct led in by		3	28e. Place of I	njury - At hom etc. (Specify)	ne, farm, str	eet, factory, off	ice		28f. Location (City or To		Number or	Rural R	oute Number,	
	ne Hospi n 24 hou ne Funer pletely fil	Medical	(Check 2 Medical Exaconly one) 3 Certifying N	hysician: To the best amîner: On the basis of lurse Practitioner: To	f examination a	and/or invest	tigation, in my c	pinion, deatl	h occurred a	at the time, date	and place, a	nd due to ti	ne caus	e(s) and manner stat	ad.
	To the vithing the complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex com		29b. Signature and title of certifier	breMD			29c. Lic	ense numbe	er 465		29d. Date	signed (Mo	nth, Da	y, Year)	
			30. Name and address of person when the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the stat	no completed cause of	death (Item 2	23a) (Type, F	Print) 5 Z	W B	Balt	more	MD	-2/	20	9	
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 9 201	32. Regis	strar's Signatu	bark	V								
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State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:30 Ам Otho S. Dutton 04 2012 17 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE SINAL HOSPITAL OF BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign Sex XXM 2□F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Country) Marvland Months Days 84 March 1, Director 217-20-3352 1928 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Michael Examiner is ust be neither at 1 ☐ Yes ≯ ☐XNo Director Reisterstown Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21136 U.S.A. 41 Bond Ave. by Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 □Yes XXNo If Yes, Give Year or Dates: Specify. Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nati any lijury or other traumatic event, the Microsone. (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Dry Cleaning 12 Route Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Clark Otho Smith Dutton ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bond Ave. Reisterstown, MD 21136 Frances M. Dutton / Wife 20b. Place of Disposition (Name of competery, crematory of other place)
St. Luke's
Church Cemetery 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 4/21/12 Reisterstown, MD 21. Signature of Juneral Septice Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. men 11605 Reisterstown Rd. Owings Mills, MD21117 ENRA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Encephalopathy **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner severe renal failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): dehydration / anorexia Hospital or Attending Physician: The law requires that the death certificate be executed Exami and Due to (or as a consequence of) P.O. Box 68760, the attending physician ned for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24a. Was an Were autopsy findings available prior to completion of cause of has performed? certificate 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Tother (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Matural 1 ☐Yes 2 ☐No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P26514 April, 17, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELVEDERE AVE, BALTIMORE, MD 21215 SINAL HOSPITAL OF BALTIMORE, 2401 W. VIVEK KALIA, MD

DHMH 17 Rev 1/2001

State

'Registrar

31. Date filed (Month, Day, Year)

APR 1 9 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>012</u> Physician/ Month April Eikenberg 15 11:21 Marean Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore Towson **Funeral** Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours **Director** 213-26-0850 1 □ M 2 🛛 F 81 June 16, 1930 Maryland Usual Residence of Decedent 3a or 28a-f shov t be notified at 10b. County with the Maryland 10c. City, Town or Location Director 1 Tes 2 X No Maryland Baltimore Baldwin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a must be Funeral 13611 Devonfield Drive 21013 USA items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner r 14. Race - American Indian. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 X Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene.
item 27 is marked other than other traumatic event, the Me Residential Elementary/Secondary (0-12) College (1-4 or 5+) 12 Real Estate n/a Realtor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Tucker Helen Ann Connelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Debra A. Hauer/Daughter 7 Delgreen Court, Nottingham, MD 21236 t of Healt : If item? / or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Department of Important If any injury or St. John's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4/19/2012 Hydes, Maryland Bryan W. Clary 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 23a. Part 1. Enter the disease, or complications that caused the shock, or eart failur. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or co dition resulting in deat Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami certificate be executed burial-tra that initiated events Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe After this certificate Yes 2 L · Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PINO Horapice မ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? _1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the To the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARATHT 4105 6701 NCHARLES St SUITE RACTIMORE 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 12208 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ BERNADETTE 033 PM 701 TOV Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Mercy Medical Center If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 214-64-9976 **Director** 1 □ M 2 🛛 F Dct.10, 1916 Pennsylvania 95 Usual Residence of Deced 28a-f show permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Catonsville MD Baltimore 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 USA 103 Oak Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. 9 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 No Specify If Yes, Give Specify 3 ₩ Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Teresa Bedner John Kosco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Frederick Road #105; Catonsville, MD 21228 Eugene Fields Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 A Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 4/17/2012 | Baltimore, MD

22. Name and Address of Facility terling Ashton Schwab Witzke
Funeral Home of Catonsville, Inc. 4 Donation 5 Other (Specify) Signature of Funeral Service Linesee Þ 1630 Edmondson Avenue: Catonsville or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final lostrial Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Date to for as a done oquence of, or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has page 2 After this certificate 21/2 No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: 2 No ျပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending death. Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Medical McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier Buck, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DV 345 St Paul Back Jan lelle

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

istrar's Signature

12-02856 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 12209 Debra Ann Thompson Gibbs State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) 3. Time of Death 0502 hrs **Medical Examiner** April 12, 2012 THOMPSON GIBBS DEBRA ANN 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's Prince Georges Hospital Center Cheverly If Under 1 Year If Under 24Hrs. 8, Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours Director 02/24/1955 Country MARYLAND 1 M 2 X F 57 220-58-7305 Yrs Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d Inside City Limits 1 X Yes 2 No or items 23a or 28a-f shor must be notified at once. MARYLAND PRINCE GEORGE'S CAPITAL HEIGHTS more, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.
nett: If item 27 is answed other than "ustural", or items 23a or 28a-f sho are other trannatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6810 CENTRAL AVENUE #404 20743 UNITED STATES ineral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 XMarried 2 X No 교 Yes 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2 X No specify: Specify: BLACK 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE 12TH NURSE'S AIDE 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) D. THOMAS THOMAS WESLEY ROSS MARY 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3732 APOTHECARY STREET, DISTRICT HEIGHTS, MD 20747 NADINE BRADFORD / DAUGHTER 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c, Location - City or Town, State Date crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department or Important: I 4/19/2012 RIVERDALE, MARYLAND RIVERDALE CREMATORY 4 Donation 5 Other Specify 21. Signature of Euneral Service Licensee 22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD, HYATTSVILLE, MARYLAND 20785 23a. Par II Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause I Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Die to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the use as t 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown for Unknown by the Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. this certificate has been signed þ 1 Yes 2 No 3 Probably 4 ✔ Unknown Endstage renal disease Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes ✓ Yes 2 No - No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) funeral director. a Hospital: 1 Other₄ DOA Inpatient 2 PER/Outpatient 3 Nursing Home 5 Residence 6 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No Pending the 2 Accident Investigation completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical one) 2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) OCME April 12, 2012

State

Registrar

arke

32. Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year Martin Robert Gross 130 KM 2017 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Director 162-14-5375 1 🛣 M 2 🗆 F Oct 5, 1917 Pennsylvania 94 28a-f show 10a. State the Maryland at 10c. City, Town or Location Director 10d. Inside City Limits Annapolis 1 Tes 2 No Anne Arundel 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 21401 968 Shadewater Way USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant if item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner muy or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. white 3 Divorced 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4 or 5+) engineering ed other i US government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Martin George John GRoss Hilda Rosa Frisch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Gross/spouse 968 Shadewater Way Annapolis, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 Other (Specify) State and Address of Facility and 655 W. Baltimore Street rector 2120 MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or meart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ig physician and as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
 5 Other (specify) page 2 should be detached for in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed' Yes 2 No Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes 2 ANO ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Definition in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ρ 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

Registrar APR 1 9 2

31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a)

registrar's Signature

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			For Amend Item 26 State of Maryland I - State Registrar	04P Cer	1972012di tificate of D	Balth and Seath	l Mental H	ygiene Reg. N		12	12211
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н	Physicia Medic		Edward Clyde Green				Month March	26		rear 12	3:03A ^M
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rest.	Funeral		Harford Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birt)	hdav)	Havre If Under 1 Year	de Grac		J 3irth	Harf		ace (State or Foreign
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36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 No If Yes, Give	If	Vas Decedent of His Yes, specify Cubar Yes 2 X No	n, Mexican, Pue		0-	14. Race - Black, Specify:	White, et	tc.
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State of Maryland / Department of Health and Mental Hygiene												
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12	within 72 hours after death with the Maryland giene. greet than "natural", or items 23a or 28a-f show the than "natural" or items the notified at the Medical Examiner must be notified at the medical Examiner must be notified.		215 - 05 - 1086 1 □ M 2	2 💢 F	97 Yrs.	Months Days	Hours Min.	(Month, Day, 109/22/		Country)	JSSIA	
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		J.	17. Father's Name (First, Middle, Last) GERSHON	T.	INKNOWN	, l	18. Mother's Name	,	aiden Surname	UNKNO	TATNT	
			19a. Informant's Name/Relationship (Type, Print)		12			ural Route Number, City or Town, State, Zip Code)			AATA	
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Bal			21. Signature of Funeral Service Licensee		22	. Name and Address				-		
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Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2.	Medical Certificate:	3 Suicide 6 Could not be	e. Place of Injury - At ho				28f. Location (Str		r or Rural Route	e Number,	
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	Hospi 24 hou Funer tely fil		29a. Certifier (Check Check 29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
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30. Name and address of person who completed cause of death (item 23a) (Type, Print)											1061	
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month 710 PMM **Physician** gini armor /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner more Baltimore NUVSIN 0 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Social Security Number **Funeral** 1 □ M 2 F Months Days Hours Director 1920 Colorado Nov Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show natified at 1√2Yes 2□No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number item 27 is marked other than "natural", or items 23a or other traumatic event, the Wedical Even in the court be-124 W. Franklin Street #1402 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. If Yes, Give A Year or Dates Specify: white þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within ; th and Mental Hygiene. **7 is marked other than "**r Elementary/Secondary (0-12) College (1-4or 5+) food industry 6 waitress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lula Jeanette Kirker John Bachuss ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trains 5929 Ayleshier Road Baltimore, MD 21239 Donnet Lawrence/friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4∏ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Ronald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street /Director 21201 Baltimore, MD Approximate Interval Between Onset and Death 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** maliznanos /Medical Due to (or as a cd - quence of): Examiner pulmonary Sequentially list conditions Lub to (or as a consequence of): Examiner rany, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 74042ars law requires that the death certificate be executed attending physician and for use as the burial-transi-Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Ye ar in the past 12 months? Day 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown icate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐Yes 2 ☐No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760,

Saltimore, Maryland 21215-0036

To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After filled in by the completely

29a. Certifier (Check only one)

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16 Novah Rockblan Rd. CRNP Imeier, 173 De Registrar's Signature i Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ 2012 Diane Grace Habicht Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours 218-70-9127 Director 1 □ M 2 🛛 F 56Yrs. Feb. 22, 1956 Maryland Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location Director MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be n 10g. Citizen of What Country? Funeral 10311 Malcolm Cir., Apt. D 21030 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Completed by 1 Yes 2 X No Specify If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates er than "natura", the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Public Sector/ College (1-4 or 5+) Elementary/Secondary (0-12) Journalist/Press Secretary Government is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evence, Roland R. Habicht Betty Jane Merrill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3032 Bird View Road Westminster, MD Brian Habicht/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of April 18, 20c. Location - City or Town, State cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) $\bar{2}\bar{0}1\bar{2}$ Timonium, MD 21. Signature of Funeral Sprice Lio insee 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Road Timonium, MD 21093 nehael J. Flagle se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, this only one cause on each line. . Part 1 Enter the dised Immediate Cause (Final obable Myocardia Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 $^<$ IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be multiple sclenosis 1 Yes 2 No 3 Probably 4 Unknown im multiple sclevisis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier 🚅 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifie 29d Date signed (Month, Day, Year) Oyuthia small No 00057347 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N charles It Towson MD Sosiano MO 6701 whena

7:44 P M

10d. Inside City Limits

Approximate Interval Between

Onset and Death

2 1 No

1 Yes 2 X No

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month / Physician/ Hal Medical Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Count Medical ata tenter 9. Birthplace (State or Foreign Country) Virginia If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday, Security Number 6. Sex Funeral 1 □ M 2₺ Min. oct. 13, 1917 Months Days Hours 94 233-52-5658 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Charles Waldorf MD10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 4140 Old Washington Road 20602 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No White 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carol Elmer Blankenship Emma Greer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Jean Mitchell-Daughter 315 Council Bluff Parkway, Murfreesboro, TN37127 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date orial 2 Cremation 3 - Removal from State 4-20-2012 Princeton, WV Roselawn Mausoleum 4 Donation □ Other (Specify) 22. Name and Address of Facility Metropolitan Funeral Service 21. Sign ture of Funeral Service Lightsee 5517 Vine Street, Alexandria, VA 22310 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final associa Physician Healthcare disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trans and that initiated events Due to (or as a consequence of): resulting in death) Last tor. After this certificate has been signed by the attending physician the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 Yes 2 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 2 No 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Medical

24 hours after deat Funeral Director: completed filled in by within 2 To the

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

72031

2012

Name and address of person who completed cause of death (Item 23a) (Type, Print)

24becca Powell 701 E. Charles St La Plata

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRIL 16, 2012 12:28aM DARRYL HASKINS, JR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 16 BARNACLE COURT **ESSEX** 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 7. Age (In vrs. last birthday) Days Min (Month, Day, Year) Country) Director 218-98-7973 1 **X** M 2 □ F 29 04/27/1982 MARYLAND 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director ms 23a or 28a-f s must be notified 1 🗌 Yes 2 🔀 No MD BALTIMORE **ESSEX** 04/16/2012 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16 BARNACLE COURT 21221 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 9 ģ 1 Never Married 2 XMarried ムケップ L しんらんいろ メゲッフル Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced Specify. BLACK "natural", Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) the PERSONAL TRAINER FITNESS Be Lagkins 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ၉ DARRYL RENEA MARIA PROCTOR HASKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is a any injury or other traur Page 1 and 2 s ment of Health a SHANI PATTERSON/WIFE 16 BARNACLE COURT, ESSEX, MARYLAND 21221 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OAK LAWN CEMETERY 4/20/12 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) Signature of Funeral Licensee 22. Name and Address of Facility LTLLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTO., MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) q I linknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been signe page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Hospital or Attending Physician: The law autopsy 1 ☐ Yes 2 No this certificate 25. Was case referred to medical examiner?
Yes 2 \(\sqrt{N} \) No director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Self Certificate: 28c. Injury at work? 1
Natural 5 Pending injury 114/2012 1 Yes 24 hours after death. Funeral Director: A un S Accident Investigation 0028 filled in by the 3 Suicide 6 Could not be Place of Injury - At hor building, etc. (Specify) f. Location (Street and Nun City or Town, State) 28e At home, farm, street, factory, office determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause's) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Understripping Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 8 ompleted cause of death (Item 23a) (Type, Trim (Month, Day, Year) APR 1 9 2012 2. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 4 Physician/ 8: 45 PM DONNA HTCHCOCK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 309 Washburn Ave #1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Min. Hours 64 Director unk 1 □ M 2 🛣 F Yrs 12/04/1947 MD or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō an "natural", or items 23a o Medical Examiner must be Funeral 21225 USA 309 Washburn Ave #1 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry filed within 72 tal Hygiene. life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Gov't Administrative Assist 14yrs Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be file h and Mental F 7 is marked of Paul William Shannon ൧ Mary Cecelia Burns traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a tant: If item 27 is 228 Marganza South Laurel MD 20724 Brian Hitchcock Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State ō Department of Important: If any injury or once. 4/16/12 Glen Burnie MD Atlantic Crem 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv Thomas Allen PA 7090 Ridge Rd Hanover MD uneral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ CARDIAC disease or condition resulting in death) Medical Due to (or as a consequence of Examiner CONVESTIVE Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the attending physician and shed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☒ No Pregnant at time of death 1 ☐ Yes ∠ ≠ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hyperrension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No Yes 2 Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica etely filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner?

1 \(\sum \text{ Yes} \quad 2 \) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 29c. License number 29b. Signature and title of certifier D0066548 1235 E. MONUME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARR

₩ DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2012 Year Physician/ $\overset{\scriptscriptstyle{\mathsf{MODIN}}}{\mathsf{APRIL}}$ 1:00 P M **DEBORAH** MARIE JACKSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours Min DEC. 1 389-66-3775 56 1955 WISCONSIN Director 1 □ M 2X F Usual Residence of Deceden or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No PRINCE GEORGE'S MD MITCHELLVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? of Mental Hygiene. marked other than "natural", or items 23a or matic event, the Medical Examiner must be I Funeral 1720 ALBERT DRIVE 20721 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11 Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 **X** No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) filed within PROGRAM ANALYST PRIVATE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Page 1 and 2 should be GEORGE HATHAWAY DELORIS FRAZIER and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FREDERICK JACKSON/HUSBAND 1720 ALBERT DRIVE MITCHELLVILLE, MARYLAND 20721 if Health 20b. Place of Disposition (Name of cemetery, crematory or other place)
TRINITY CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important; If ite any injury or ot 1 Warrial 2 Cremation 3 Removal from State 4/23/2012 WALDORF, MARYLAND 4 Donation 5 Other (Specify) Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature Kusas 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 wo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mod shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) neo Medical D to (or as a consequence of) Examiner Sequentially list conditions. flary losding to immediate. Enter Underlying Cause (Disease or injury Due to for as a consequence off burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical requires that the death certificate be Box 68760 the as nding p IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No jo Month Pregnant at time of death 5 Other (specify) signed by the a 1 | Yes 2 | 9 | Unknows 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Hospital or Attending Physician: The I 24 hours after death. Funeral Director; After this certificate h 1 Yes 2 No Yes 2 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Yes 2 🗆 No To the Hospital or Attending Prysic within 24 hours after death.

To the Funeral Director, After this completely filled in by the funeral director. ည Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify home 28d. Describe how injury occurred F Twice. on Apr 27. Manner of Death Date of injury (Month, Day, 28b. Time of 28c. Injury at Certificate: Natural Accident pri 12 5 Pending TWICE 1916, 2012 500 1 Yes Investigation 3 Suiciae 4 Homicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined MARYLAND Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar

only one) 29b. Signature and title

Date filed (Month

nd address of

DHMH 17 Rev 06-2011

23a) (Type, Print)

29d. Date signed

(Month, Day

Physician/ Medical Examiner certificate be Box 68760 the P.O. ģ Records, certificate has Division of Vital or Attending Physician: the Hospital

attending physician and I for use as the burial-tran page 2

Funeral

Director

28a-f show

5

ral", or items 23a Examiner must b

27 is marked other than "natural", traumatic event, the Medical Exa

and N

permit. Page 1 Department of Important: If it any injury or o

Baltimore, Maryland 21215-0036

be notified at

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	best of my knowledge, death occurred at the time, date and place,	
	asis of examination and/or investigation, in my opinion, death occurred	at the time, date and place, and due to the cause(s) and manner stated that and out to the passin(t) and manner as its table.
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
I hours K. Go	20.0 mm 231660	4/13/12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THUMAS	K.	GAWIMMA	295	STONER	nerve	wes min sten	MA	2115

State Registrar

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registra 1-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year Day **Physician** 2027 PM 2012 pandra 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 □ M 2X F 214-56-9868 62 Yrs 06/02/1949 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2XXNo Director MD Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code ò death with 23a 7915 21224 East Dale Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 P. 1 ☐ Yes 2XXNo Specify: 2 Specify: 3XXWidowed 4 ☐ Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked ၉ Forrest Dobbins Edna_Bragg daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau once. 7915 21224 Ms. Vanessa G. Kerwath East Dale Road, Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/19/2012 Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specily) Glen Burnie, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 1 2nd Ave, SW Glen Burnie, MD Moiss7 Singleton Funeral & Cremation Services, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** troke day disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3

Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 2 No 1 TYes P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed t 2 Records, 2 No 3 Probably 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 performed' Division of Vital certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 1 ☐ Yes 2 ▼No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 3 □ DOA 2 ER/Outpatient Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 🗌 Yes 2 🗌 No 2 Accident after death. 6 Could not be determined 3 🗌 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funeral C completely filled filled Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gerard 4940 Eastern Avenue, Baltimore, MD, 21224 CAST 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1353 M Myra Nell Leyhe APRIL 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospita
Social Security Number 6. Sex 7. altimore If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Feb 2,192 . Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 - M 2 X F Months Min. Alabama **Director** Yrs 424-14-337° 90 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Catonsville 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funera 21228 USA 717 Maiden Choice Lane #ST413 items (death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, the Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 No within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White "natural", Completed 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) ge 1 and 2 should be filed within 72 it of Health and Mental Hygiene.

If item 27 is marked other than "r or other traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) House wife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ada (unk.) Charles Walker 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode)
3263 Rolari Dr. Taneytown, MD 21787 Charles W. Leyhe Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State = 5 1 Burial 2 X Cremation 3 Removal from State Department or Important: If any injury or 4/20/12 Glen Burnie, MD 4 Donation 5 Other (Specify) Atlantic Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Home MD 21229 Hubbard Funeral 4107 Wilkens Ave. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Severe-3 vessel coronary Artery disease Physician/ years disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ardial inFarction Gause (Disease or linjury Examine or as a consequence of: -transit death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a ned for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 9 Unknown 9 I Inknow P.O. Physician: The law requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal failure ŝ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy performed 2 🗆 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 욘 1 Tyes 2 No 2 ER/Outpatient 3 DOA Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Division of e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: Date of injury 28b. Time of 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pending Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) To the Hospital of within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature atel

State Registrar

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BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patel

APR 19

900 S. CATOM AVENUE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret A. Lopreato Month Day 2012 8:00 P M Apri] Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death
Carroll County 4b. City, Town, or Location of Death Hampstead Golden Crest Assisted Living Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign Days Hours 215-24-8087 **Director** 1 □ M 2 🛛 F 82 Jan. 4, 1930 Maryland ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PA York County Glen Rock 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 4169 Huffmanville Road 17327 United States Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black White etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 should be more and Mental Hygiene. white 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) secretary Lvon Conklin Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Lampen Josephine Wertz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod. 13120 Falls Road Cockeysville, Maryland 2 George E. Chenoweth, Jr./nephew Cockeysville, Maryland 21030 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite 20c. Location - City or Town, State April 9 2012 1 X Burial 2 Cremation 3 Removal from State Dulaney Walleyther place, Timonium, Maryland 4 Donation 5 Other (Specify) Memorial Gardens Signature of Funeral Service Lice 22. Name and Address of Facility Eline Funeral Home any M01072 934 South Main Street Hampstead, Maryland 21074 auro 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ VINNICULA disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subsetext{ X No} \) Month Pregnant at time of death Dav Year signed by the a ld be detached f 1 Yes 2 2 9 Unknown q I Ilnknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 V Yes 2 □ No 3 □ Probably 4 □ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? page performed? Yes 2 X No 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) assisted examiner's 1 ☐ Yes 2 X No Hospital Other: living facilit မ 4 Nursing Home 5 Residence 6 K Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely To the I within 2 To the I 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 32) of nomas J. Vento, MD Thomas J. BUSINESS CENTER DRIVE

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

"natural", or items 23a 21215-0036 Il Hygiene. permit. Pages 1 and 2 should be filled wi Department of Health and Mental Hygien Important: If item 27 is marked other th any injury or other traumatic event. Saltimore, Maryland

and P.O. Box 68760 physician Records, Division of Vital Hospital or Attending Physician: After death.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APR'L 14 20 T2 DOROTHY E.K. LOGWOOD **Physician** 1730 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY ADELPHI HEARTLAND HEALTH CARE CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 1 0 / 1 5 / 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 □ M 2 □ F Hours PENNSYLVANIA Months Days 1905 159-26-7925 106 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show traumatic event, the Medical Exeminer must be notified at 1√2 Yes 2 □ No Director MONTGOMERY MD ADELPHI 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 1801 METZEROTT RD 20783 UNITED STATES Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married BLACK 1 □Yes 2 ☑ No If Yes, Give Year or Dates Specify. Specify: 2 3Ñ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SCHOOL TEACHER EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM KELLAM MARGARET WARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MURIEL SINGLETARY/NIECE 3900 AMY LANE RANDALLSTOWN. MD. 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>LAWN CEMETERY: 4/23/2012 SHARON HILL, PA</u> 22. Name and Address of Facility 21. Signature of Funeral Service (Menses CAPITOL MORTUARY 11425 MARYLAND AVE NE WASH., DC 20002 -f, or complications that caused the death. Do intenter the mode of dying, such as cardiac or respiratory arrest, List/inly one cause on each line. 23a. Part 1. Enter the diseas-shock, or heart failure. Immediate Cause (Final Vascus **Physician** disease or condition resulting in death) /Medical Due to (*r * s a consequence of): Examiner Lonos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Diabites the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2-1 No Month Year Day 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2□No 24a Was an Imant 1 □Yes 2 10No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Mo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral (28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: completely filled in by the f 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 47867 and file of certifie 29d. Date signed (Month, Day, Year) 29b. Signatur rson who completed cause of death (Item 23a) (Type, Print) Pd + ZIE. ROCKVILLE, HD ZOSSZ. 4701 Randolph 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

12-02934 James Leonard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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James Leonard		For State	Otate .	or waryland	Certi	ificate of	Death		, ,	Reg.		712 12	
Physician		egistrar . Decedent's Name (Fi	rst, Middle,Last)					Mo	te of Death	Day Year	3. Time of Death 0351 hrs	1
Medical Examine	er	James Rus							Арі	ril 15, 20	12		
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MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23s or 28s-fish unative event, the Medical Examiner must be notified at one	우	Juanita L.			-						MD 21001		
MD and 2 sho calth and com 27 is	ŀ	20a. Method of Disposi		7 515551	20b. P	lace of Disposi	tion (Name of c		Date			ity or Town, State	
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Physician	ᅥ	23a. Part/l. Enter the d	isease, or comp	oligations that caus	ed the death.	Do not enter th	e mode of dying	g, such as ca	ardiac or resp	iratory arres	st, shock, or heart	Approximate li Between Ons	
/Medical		failure. List only of Immediate Cause (Final	one cause on ea	Hypertensive								Death	
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Box 687 e death certific the attending p ed for use as th	Physician/	past 12 months?			at time of de		her (Specify)						
Box death he atte	ysi	1 Yes 2 No		9 OHRHOW						oo- Did to	hassa usa contrib	ute to the cause of dea	ath?
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that the ras after death. **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach.	tific	3 Suicide	Could no	t De	of Injury - At h	ome, farm, stre	et, factory, offic	e building, e	etc. 201.	or Town, S		or real arrests realis	
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Certification:	4 Homicide 29a. Certifier	determin	cian: To the best of		Jan Jan H	erod at the tim-	date and al	lace and due	to the caus	e(s) and manner:	as stated.	
be Fe Fe Policies		(Check only one) 2 M	ertifying Physi ledical Examin	clan: To the best of er:On the basis of	examination	ige, death occu and/or investiga	tion, in my opin	ion, death o	ccurred at the	time, date	and place, and du	e to the cause(s)	
Som Som Som Som Som Som Som Som Som Som	Medical	29h Signature and	le of certifier	and manner stat	ed.	100		ense number				d (Month, Day, Year)	
		2/1	9/	16	11.6	200	0.0	C.M.E.			April 17, 20	12	
		30. Name and address	s of person who	o completed cause	of death (Iten	n 23a)					<u> </u>		
2		Victor Weedr	MD JD	Assistant Med	ical Exami	ner 900 V	V. Baltimore	Street, E	Baltimore,	MD 2122	23		
S	tate	31. Date filed (Month,	Day, Year)		strar's Signat	la ba	4.1						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1:30 Medical Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death SAMARITAN NURSING CENTER 3ALTIMORE 7. Age (In yrs. last birthday) 85 Yrs. If Under 24 Hrs. 8. Date of Birth Social Security Number If Under 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 ▼F Days Min. (Month, Day, Year) 217-22-3211 Director Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Nes 2 □ No MD Baltimore 10e. Street and Number 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 21239 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify: BLACK 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ျ FLEMING BRUCIE 2016e MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/2/44 Ct., Apt 108, BALTIMORE Montrell Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 L r
4 Donation 5 Other (Specify) Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Baltimore 2012 Signature of Funeral Service License CI JONES FIH, P.A. E used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on Interval Between Immediate Cause (Final Onset and Death mician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examine been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed 2 No 1 Yes director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and 29c. License number 30. Name and ddress of person who completed cause of death Item 23a) (Type, Print) cl Jalel 1201 May (Month, Day, 32. Registraris State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#2perPHYS, G926, 4/25/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ERIC **EDWARD** MORGAN 2012 APRIL 6:50 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S LANHAM 5526 RUXTON DRIVE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 X M 2 🗆 F 58 **Director** 12 033-42-9923 1954 MASSACHUSETTS APRIL Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD PRINCE GEORGE'S LANHAM 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** I 5526 RUXTON DRIVE 20706 USA permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Examiner Armed Forces?

1 X Yes 2 No PERSIAN-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. o þ 1 Never Married 2 X Married Yes, Give 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: BLACK "natural" Completed 3 Widowed 4 Divorced Year or Date-GULF WAR Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) the Me Elementary/Seconday (0-12) College (1-4 or 5+) marked other t ELECTRICIAN PRIVATE Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ဂ Health and Ment: tem 27 is marked other traumatic e EDWARD F. MORGAN AMY DIXON 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NUGENT-MORGAN/WIFE 5526 RUXTON DRIVE LANHAM, MARYLAND 20706 RHENDA item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Department of Important: If it any injury or o ō 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) MD VETERANS CEMETERY 4/23/2012 CHELTENHAM, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the adath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final RESPIRATORY FAILURE Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner AMYOTROPHIC LATERAL SCLEROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Other (specify) Month Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signe page 2 should be DIABETES MELLITUS TYPE II 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? **ESSENTIAL HYPERTENSION** 24a. Was an autopsy performed? Yes 2 XN 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 🛣 No Be funeral director, 26. Place of Death (Check only one) Hospital: Other: ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 XNatural iniury 5 Pending 2 🗌 No Accident
Suicide Investigation thin 24 hours after deat the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) the Hospital Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) To the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Muli MUD #ME91750 APRIL 16, 2012

Registrar
DHMH 17 Rev 7/2009

State

ROBERT MARK KAISER, M.D., VAMC, 50 JRVING STREET NW, WASHINGTON, DC 20422/688

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 18, per fh, g926 4-26-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 7:10A [™] Margaret Himich Morris Medical April 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Autumn Assisted Living</u> <u>Cockeysville</u> <u>Baltimore</u> Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days (Month, Day, Year) Hours Min. Country) **Director** 043-16-8980 93 Ju1v 1918 Connecticut Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits **Funeral Director** 1 Yes 2 X No Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10881 York Road 21030 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner 14. Race - American Indian Armed Forces 1 Never Married 2 Married Black, White, etc. Completed by ☐ Yes 2 🎇 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes. Give 3 X Widowed 4 □ Divorced Specify: Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 2 should be filed within 72 | h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 04 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Himich Bertha Belensky Blensky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to Dr. Brian H. Morris/Son 810 Ramshead Circle, Cockeysville, Maryland 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/18/2012 Atlantic Crematory Glen Burnie, Maryland 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, Maryland 21093 24. Signature of Fungral Service Licensee Bryan W. Clary 23a. Part 1. Enter the distrise, or complications that cau led the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (as a consequence of) Cause (Disease or i that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 XNo
9 Unknown Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Fubrillet Records, Completed 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Spi Hospital: ASSISTED မ 1 Inpatient 2 ER/Outpatient 3 DOA in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending iniury within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined npleted filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R125808 Anna Lewis, CRNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ×4105 Baltimore, MD State Registrar

68760

Box

P.O.

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 12228 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 1 A Pay 2012 Agnes Majchrzak 21:48 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral Director** 216-20-3615 1 □ M 2🏋 F 85 04/06/1927 Maryland Usual Residence of Dec or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Harford Bel Air 21:48年172年173 10e. Street and Numbe 10f, Zip Code 10g, Citizen of What Country? Funeral 108 North Lynbrook Road 21014 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XNo 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. Majchrzak, Agne Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 8 Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Adam Oracki Clara Jakubowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Majchrzak - Son 108 North Lynbrook Road Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place, Crownsyille MD VA 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 04/23/2012 Donation 5 C Other (Specify) Crownsville, Maryland 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, Maryland 21231 21. Sign ture of Funeral Service Licenses 1. Enter the disease plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List Immediate Cause (Final Physician/ Hemort hagic disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death signed by the a 1 ☐ Yes 2 № 9 ☐ Unknown 9 Unknown n/# 8005,3335(Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? certificate 2 🗌 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No Other: ည 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred Hospital or Attending 1 V Natural iniury Accident 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of Artifier 29d. Date signed (Month, Day, Year) Integnal 4/15/12 Medicine 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21014 500 Upper Chesapeake 9 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Wilbur L. Martindale, Jr. 8:45 A.M <u>April</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Pasadena 7640 Laurel Drive Anne Arundel Social Security Number Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) 218 22 9074 **Director** 1 🕱 M 2 🗆 F Yrs 84 Maryland 02/07/1928 Usual Residence of Decedent 28a-f show 10a. State 10c, City, Town or Location 10d. Inside City Limits notified at rector Maryland Anne Arundel Pasadena 1 Tyes 2 X No Ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or ō Funeral 7640 Laurel Drive 21122 U.S. items 2 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 1. Marital Status "natural", or iter Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: White 3 Widowed 4 Divorced Completed the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 and Mental Hygiene. within 72 Elementary/Second 12th College (1-4 or 5+) condary (0-12) Self Employed Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lillian Garey Wilbur Martindale, Sr. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7640 Laurel Drive Pasadena, Maryland 21122 Angela Martindale / Wife 7640 Laurel Drive Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Cross Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State 04/16/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 perone 23a. Lart 1. Enter the disease, shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death ARKINSONS Physician 10 year disease or condition Medical resulting in death) **Examiner** 2 weeks rneumonia Sequentially list conditions, if any, leading to immediate cause. Enter United lying Cause (Disease or injury that initiated events resulting in death) Lact Examine Due to (or as a consequence of) nding physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 the as IF FEMALE: Was deceded in the past 12 month Yes 2 No use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for Month Day Year Pregnant at time of death the P.O. signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4
Nursing Home 5
Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ည this After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 \square Pending n 24 hours after over. The Funeral Director: After the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the functin Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2.

To the F

complet only one) 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

AXI

Oak Point Ct Pasadena

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lek

7900

Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed "	within 44 hours after beaut. To the Furnal Director, After this certificate has been signed by the attending physician and commonly directors after the function of the function of the burst formal directors. On bound by dependent for the burst formal directors.

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			o /Eimt Middle	2 / ast)			Ce	rtificate	of L	Death	2. Date of I				
Physicia Medic						e C. N	lonco				Apri Apri		B, 20		3. Time of Death 2:42 P.M
Examin		4a. Facility Name (if Glen Bu	ırnie H	lea1th					G1	Location of Dea en Burn	ie		4c. County		Arundel
Funeral Director		5. Social Security No. 185 12 3		6. Sex 1	2 X F	. Age (In yrs. 93	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min			219	9. Birtl Cou	nplace (State or Foreign Intry) PA.
show d at	tor	Usual Residence of 10a. State	10b. County		. 1 . 1	10c. C	ity, Town or L								10d. Inside City Limits
r 28a-f	Direc	Maryland 10e. Street and Nun		e Aru	naeı		Glen H	10f. Zip				100	Citi	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	1 🗆 Yes 2 🔀 No
h with th	Funeral Director	7355 E.		ce Bra	anch l	Road	-	101. 2.10		1060		Tug.	U.S.	what Col	untry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status1 ☐ Never Marr3 X Widowed		ried	Was Deced Armed Ford 1 ☐ Yes f Yes, Give Year or Date	2 🗶 No	.S. 13.	Was Deceded of Yes, special Yes 2	ify Cubai	spanic Origin? (5 n, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	0-		ck, White	ican Indian, , etc. Thite
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Page 1 ar nent of He ant: If iter Iry or oth		20a. Method of Disp 1 X Burial 2 4 Donation	Cremation		oval from S	tate	Place of Disp cemetery, cre dar Hi	matory`or ot	her plac		Date 17/2012				Town, State Maryland
permit. Departr Imports any inju		21. Signature of Fu	neral Service I		mu	our	W	2. Name and		s of Facility G	once Fu	nera alti	al Sei	rvice Mai	P.A. ryland 21225
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e e	dical E	resulting in death) l	Last	L _d	Due to (o	r as a consec	quence of):								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 I 1 Yes 2 S 9 Unknown	months? ☐ No		1 🔲 Live B	ant at time of	tal death 3	☐ Ectopic p		у		-		ate of deli	very Day Year
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ital or Att irs after d al Direct led in by i		4 Homicide	determ			f Injury - At h g, etc. <i>(Specii</i>	iome, farm, st	reet, factory,	office		28f. Location City or T			er or Run	al Route Number,
he Hospi in 24 hou he Funer pleted fill	Medical	(Check 2	Medical I	Examiner: (On the basis	of examination	on and/or inve	stigation, in n	ny opinio	date and place, in, death occurred time, date and p	at the time, date	and pla	ace, and du	e to the c	ause(s) and manner stated.
To t		29b. Signature and	10	, m	فسارن	, M.D.				number 753			Date signe		Day, Year)
3		30. Name and addre	ess of person	who compl	eted cause	of death (Iter	m 23a) (Type,	Print)	7.	BALT	MORE	, M	D 2	112:	15
Stat Registra		31. Date filed (Mont	h, Day, Year)	2012	Z. Rec	gistrar's Sign	ure for	del							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 15 Day Physician/ 2012 Michael Anthony Machado 4:40 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 719 Maiden Choice Lane BR237 Catonsville Baltimore 8. Date of Birth
(Month, Day, Year Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Year) 1<u>918</u> Days Hours Min 1 🖾 M 2 🗆 F India Director 93 300-40-9309 Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2K No MD Baltimore Catonsville 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 719 Maiden Choice Lane BR237 21228 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Asian 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates ed other than "nature event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i. Page 1 and 2 should be file tment of Health and Mental tant: If item 27 is marked c jury or other traumatic eve Hypolito Estelano Machado Maria Avelina dos Remedios 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Machado Wife 719 Maiden Choice Lane BR237; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cemetery 4/18/2012 Baltimore, MD 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Furreral Service Licensee MO1234 1630 Edmondson Avenue: Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between O set and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. cause. Enter Underlying Due to for as a consequence of, Exami Cause (Disease or linjury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician at be detached for use as the burial. Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records. 2 No 3 Probably 4 Unknown 1 Tyes To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at after death. Director: After Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nume Practioner: To the best of my knowledge, or all accounted at the time, date and place, and due to the reuse(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number ause of death (Item 23a) (Type, Print) 30. Name and address of person who comple 0 711 Maiden Choice Lo Catonsville MD 21228 Myla Carponter 31. Da e f d (Morth, Day, State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 12232 Joseph John Miller Certificate of Death 1- For State Reg. No. 2. Date of Death Time of Death 1, Decedent's Name (First, Middle,Last) Physician/ Month Day April 13, 2012 1959 hrs Joseph John Miller Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** 221 Oak Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number **Funeral** Hours Months Days 12/31/1947 64 Country) Director unk 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 1 Yes 2X No Essex Baltimore MD or 28a-f show or items 23a or 28a-f shomust be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 USA 221 Oak Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 Never Married 2 Married 1 X Yes 2 White Specify: 4 Divorced If Yes, Give Year 968-71 1 Yes 2 No specify: 3 Widowed 3 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) the Medical Exam Be Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Superfresh Bookkeeper 21215-0036 12yrs 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) Hilda Glock Albert Miller Sr. event, t 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1811 Middleborough Road Essex MD 21221 Albert Miller Jr Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition Baltimore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 04/17/12 Glen Burnie MD Atlantic Crem 4 Donation 5 Other Specify: 5 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Sign and of lineral Service Licens ThomasAllen PA 7090 Ridge Rd Hanover MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death /Medical e. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED the attending physician a ned for use as the burial -UNPENDED 23d Date of delivery Records, P.O. Box 68760, 23c, if yes, outcome of pregnancy IF FEMALE: 3 Ectopic pregnancy 23b. Was decedent pregnant in the Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the 1 Yes 2 No 3 Probably 4 V Unknown <u>۾</u> Gastrointestinal bleeding Completed 24b. Were autopsy findings available 24a. Was an After this certificate has been funeral director, page 2 should prior to completion of cause of autopsy death? performed Yes 2 V No 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 Inpatient 2 Other₄ Nursing Home 5 Residence 6 🗸 Other: Scene DOA ER/Outpatient 3 1 🗸 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 Yes 2 No 1 🗸 Natural Pendina within 24 hours after death.

To the Funeral Director:
completely filled in by the f 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 Could not be or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 14, 2012 O.C.M.E 30. Name and address of person who completed cause of deal of tem 23a 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner Zabiullah Ali, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year)

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 12233 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deal Nonth Physician/ 30 TM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore Season's Hospice If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 044-70-4268 Director 1 XM 2 F 11/07/1963 Connecticut 48 Usual Residence of Dec 28a-f shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2X No Anne Arundel Davidsonville MD ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21035 U.S.A. 726 Sunpoint Rd. items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc ō þ 1 Never Married 2 Married 1 Yes If Yes, Giv 2X No Maryland 21215-0036 1 ☐ Yes ※☐ No Specify: Specify: Black "natural" 3 Divorced 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ift. Page 1 and 2 should be They artment of Health and Mental Hygiene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Boat Detailer Self Employed years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carol E. Dortche Colburn Thompkins 19a. Informant's Name/Relationship (Type, Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other tranonce. Ellecia Thompson-Smith 210 Wolcott St., New Haven, CT., 06513 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State Baltimore, MD on-site Crematory 4 ☐ Donation 5 ☐ Other (Specify) Forephores of Brown Jr. Funeral Home PA Signature of Funeral Service Licensee MD21217 2140 N. Fulton Ave., Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ um disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 Pregnant at time of death g Unknown Month be detached Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? Yes 2 death? After this certificate 1 Yes 2 🗆 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Other: 4 Nursing Home 5 Residence 1 Tes 100 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death. To the Funeral Director: At 1 🗌 Yes 2 🗌 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ame and address of person who com ause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

2012

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year PATRICIA MCDANIE April Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death N/A UNIVERSITY of BALTIMORE MARYLAND MEDICAL If Under Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 213-34-9663 Months Hours Director 1 □ M 2 🕱 F 74 03/25/1938 Ν. Usual Residence of Decede Carolina or 28a-f show notified at 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Co. 1 Yes 2 XVo MD Owings Mills 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be Funeral 4507 Lyons Run Circle Apt 103 21117 U.S.A. er than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☒ Widowed 4 ☐ Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mential Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 4+years Program Manager Great Oak Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Otis G. Cox Geraldine Gaither 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip CMD 21117 Deborah Wiggs(daughter) 10090 Mill Run Cir. Apt207A, Owings Mills, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State on-site Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee Joseph Ad Hess of Brown Jr. Funeral Home PA uam 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death SEPSIS Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** LIVER FAILURE Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) the attending physician and ched for use as the burial-transit that the death certificate be executed ACIDOSIS ACTIC Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires CIPPHOSIS, HEPATORENAL SYNDROME DIABETES Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen s 24a. Was an Were autopsy findings available prior to completion of cause of this certificate has autopsy erform death? 1 ☐ Yes 2 ☑ No Yes 2 No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes Hospital 2 W No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) s after death. I Director: After the 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R13378 en 2012

State Registrar JUSAN

31. Date filed (Month, Day, Year)

UTREMBA

DHMH 17 Rev 06-2011

BALTIMORE

MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Shirley Estelle Nash Physician/ April 1 2012 2:35 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Timonium** 4c. County of Death **Baltimore Examiner** Stella Maris Hospice Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 214-74-2656 Hours 1 🗆 M 2 🔀 F 73 March 16,1939 **Director** Maryland Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Timonium 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 101 Oakway Road 21093 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc 2 1 Never Married 2 Married 1 ☐ Yes 2 XX io Specify: White If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last)

James Ruff Monks 18. Mother's Name (First, Middle, Maiden Surname)
Estelle Marie Topper and Mental F is marked of Department of Health and Mental Important. If item 27 is marked any injury or other traumatic ev once. ျ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Edward Nash/ Son 101 Oakway Road, Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Dulaney Valley Mem. April18,2012 Timonium, Maryland 4 Donation 5 Other (Specify) Signature of Faneral Service 22. Name and Address of Facility Lemmon Funeral Home , Inc. 10 W. Padonia Road, Timonium, Maryland 21093 Licenses 9 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 11 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 5 Other (specify) Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 No 1 Tes 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes Other: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence aide 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Natural 5 Pending work Accident Investigation 1 Yes 2 🗌 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Ve 2 300 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Terror State of Maryland / Department State Registrar	artment of Health and I	Mental Hygier	0010 10000
	Physicia Medic		Decedent's Name (First, Middle, Last) Barbara, Noel		2. Date of Death	Day Year 3. Time of Death 2012 3.50 AM M
)	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	Funeral		Gilchrist Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Towson If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimore 9. Birthplace (State or Foreign
	Director		213-32-3362 1 M 2 XF 76 Yrs.	Months Days Hours Min.	(Month, Day, Yea	Country) 1935North Carolina
	ind ihow at	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	cation	50PC 25,	10d. Inside City Limits
	Maryla 28a-f s otified	Director	MD Baltimore Tows	on		1 ☐ Yes 2 ∏ No
	th the	'al D	10e. Street and Number 305 E. Joppa Road #2005	10f. Zip Code 21286	10g.	Citizen of What Country? USA
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - American Indian,
36	after de ", or it camine	by	1 Never Married 2 Married 1 Yes 2 No	f Yes, specify Cuban, Mexican, Puerto I □ Yes 2[☑] No <i>Specify:</i>	o Rican, etc.)	Black, White, etc. Specify: black
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Maryland	should and I		1 = .	ng Address (Street and Number or Ru		1
re,	I and 2 f Health item 2 other 1		20a. Method of Disposition 20b. Place of Dispo	N. Ellamont Stre		ore, MD 21216 Location - City or Town, State
mo	Page nent or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🛣 Donation 5 ☐ Other (Specify)	natory or other place)		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Ronald S, Water Intrector St	Name and Address of Facility Late Anatomy Boar Altimore, MD 2120	d 655 W. B	altimore Street
ı	1		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter clock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Ph, i i n Medical	1	Immediate Cause (Final disease or condition resulting in death) a.	failure		Onset and Death
	Examiner		Due to or as a consequence of):			
	oit q	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):			
	ecuter and al-trans	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):			
00	ath certificate be executed attending physician and for use as the burial-transit		d			
Box 6876	ertificat ding ph	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			
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Division of Vital Records, P.O.	lor Att after c Direct d in by		4 Homicide determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of (Check 2 Medical Examiner: On the basis of examination and/or invest			
	o the l	Me	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, 29b. Signature and title of certifier,		lace, and due to the cau	
	. > 0		> Syed Blikas MD	D72139	Afo	ril 8th 2012
			30. Name and address of person who completed cause of death (Item 23a) (Type, P SYED Q. ABBAS 6701 N Charles CL. Sw		se MD 2	1204.
	Stat Registra		31. Date filed (Month, Day, Year) APR 1 9 2012			
			The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ T6 2012 APRIL 9:30 A M OVIOSA ESTHER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HEARTLAND NURSING HOME HYATTSVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Hours Mir Director 212-35-9316 79 1 □ M 2 X F JULY 31 1932 NIGERIA Usual Residence of Decedent shov 10a, State 10b. County with the Maryland Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director · 28a-f PRINCE GEORGE CHEVERLY 1 Yes 2 No 10e. Street and Number ō 10f, Zip Code Citizen of What Country? Funeral 20785 ŬSA items 23a 3101 CHEVERLY AVENUE 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ö ģ ☐ Never Married 2 ☐ Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. BLACK 3 X Widowed 4 □ Divorced "natural" Specify Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) BUSINESS WOMAN PRIVATE and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ CHARLES DALE MARY SIMEON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau GLORIA RICHARDSON/DGT. 3101 CHEVERLY AVENUE CHEVERLY, MARYLAND 20785 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 4/20/2012 BRENTWOOD, MARYLAND LINCOLN CEME. 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Tul. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph. sician PANCREATIC CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** LIVER FAILURE Sequentially list conditions, it may leading to in reclaim cause. Enter Underlying ne Due to for as a consideration of Exami Cause (Disease or injury that initiated events HYPERTENSION burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death signed by the at Id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 X No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 🛚 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 XNursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b, Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 💢 Natural 5 Pending work' 1 🗌 Yes 2 🗌 No 24 hours after death Funeral Director: A filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

within 2 To the

Registrar DHMH 17 Rev 06-2011

State

29a. Certifier (Check

3 🗌

RAMAN R. TULI M.D.

2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29b. Signature and title of certifier

31. Date filed (Month, Day, Year

Certifying Nurse reactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D19609

10810 DARNESTOWN ROAD #202 GAITHERSBURG, MARYLAND

29d, Date signed (Month, Day, Year)

APRIL 18, 2012

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Funeral Director		5. Social Security N 578-70-8		6. Sex	M 2 X F		e (In yrs. Ia O	ast birthday)	If Under Months	Days	Hours	24 Hrs. Min.	8. Date of E (Month, I)	9. Birthp Coun		tate or Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	4517 BIS		L C	IRCLE				207					Tug. (Oitizen of V USA	vnat Cour	itry ?	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Medical	(Check 2		xamine	r: On the ba	sis of ex	kamination	and/or inves	tigation, in	my opinio	n, death o	ccurred at	the time, date	and place	ce, and due	to the cau	ise(s) an	d manner stated.
o the	Ž	only one) 3 29b. Signature and	Certifying title of certifier		Practitione	r: To the	e best of n	ny knowledge		urred at the License		te and pla	ce, and due to		se(s) and material and an arrangement of the signed			r)
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State Registra	e r	31. Date filed (Mont. APR 19	2012	Den	32. F	registra	ir's Signat	ture										
		W R 0 0 0000																

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Year Evelyn Norma Pinkine 12:56 PM April Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Harbor Hospital Baltimore N/A Social Security Number 7. Age (In yrs. last birthday) 75 yrs. If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Country) Maryland 8 Date of Birth **Funeral** 1 M 2 X F Months Days Min 213 32 7962 0770471936 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 403 W. Ordnance Road Apt. 101 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 and 2 should be filed within 72 hours after d f Health and Mental Hygiene. item 27 is marked other than "natural", or i \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Receptionist St. of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Meister Anna Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Pinkine / Son 3323 Orlando Avenue Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Glen Haven Mem. Park | 04/19/2012 Glen Burnie, Maryland 22. Name and Address of Facility Gonce Funeral Service, 21. Signature of Juneral Service 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final -Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be phys. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 month Year Day Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobac v use contribute to the cause of death? Completed by Records, 1 es 2 No 3 Probably 4 Unknown HEMOD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The lorithin 24 hours after death.

To the Funeral Director: After this certificate h performed Yes 2 2 🗌 No 1 Tes 25. Was case referred to predical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☑ No <u>|</u>2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne eath 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatura a d title of certif 2012

Registrar

68760

Box

P.O.

Division of Vital

Q

State

Baltimore, Maryland 21225

5410-A Ritchie Highway

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harjit Singh, M.D.

APR 1 9 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of	Maryland / Dep			lental Hyg	iene	
		_	Registrar 1. Decedent's Name (First, Middle, Last)	Се	ertificate of D	Death		eg. No. 20	2 12241
	Physicia		and the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of th	rkins			2. Date of Death	Day ZCIZ	3. Time of Death
-	Medi Examir		4a. Facility Name (if not institution, give street and number		4b, City, Town, or	Location of Death	09 (4c. County of De	
Agree .			University of MANAMA	3	Balto	none			
	Funeral Director			Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
			Usual Residence of Decedent 1 □ M 2 🗓 F	87 Yrs.			06/01/		TN
	land f shov	to	10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	Mary 28a-i	irec	MD Anne Arundel			Hanove	-		1 Yes 2XX No
	ith the 23a or st be i	Funeral Director	10e. Street and Number 1352 German Driveway		10f. Zip Code	21076	11	0g. Citizen of What 0	
	ems arm	nne	11. Marital Status 12. Was Deceder	t Ever in U.S. 13,	Was Decedent of His	21076	cify Yes or No-		J.S.A. nerican Indian,
98	fter de , or it amine	þ	1 Never Married 2 Married Armed Forces	No No	Was Decedent of His If Yes, specify Cuban		Rican, etc.)	Black, Wh	
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates		1 ☐ Yes 2X No			Specify:	White
75	72 ho	mple	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupa e kind of work done du DO NOT use retired)		ng	16b. Kind of Busines	s/Industry
212	within giene. er the		Elementary/Secondary (0-12) College (1-4 o	r 5+) ,,,,,,,	Waitr	cess		Res	taurant
pu	e filed Ital Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		,	
Maryland	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		Scott Spicer	. alat and			th Elkin		
			19a. Informant's Name/Relationship (Type, Print) dan Mrs. Betty E. Koblinsky	ighter 19b. Mail 135	ing Address <i>(Street ar</i> 2 German	nd Number or Rura Driveway	l Route Number, (- Hano	City or Town, State, 2 Ver, Mary	
re,	le 1 and 2 s t of Health If item 27 i		20a. Method of Disposition	20b. Place of Disp	osition (Name of			20c. Location - City	
imo	Page ment c ant: If ury or		1XXBurial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, cre	matory or other place 11 Cemeter		/2012	Brooklyn	Park, MD
Baltimore,	permit. Page 1: Department of B Important: If it any injury or of		21. Signature of Funeral Service Licensee		2. Name and Address	-	2nd Ave,		n Burnie, MD
	40 = 60	Н	23a. Part 1. Enter the disease, or complications that cause		Singleton				IV .
	Physician/		Immediate Cause (Final	ne.	ter the mode of dying	, such as caldiac o	r respiratory arres	il,	Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death) a. Due to (or a	s a consequence of):					Tuesk
-	Examiner	<u>.</u>	Sequentially list conditions, b. Cryo	liac Arr	ythmia				15 minutes
	ed Isit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	s a consequence of):	1				1.
	xecut	Еха	that initiated events c.	s a consequence of):					
09	ate be executed hysician and the burial-transit	dical	d						
	rtificat ing ph e as th		IF FEMALE:						
Box 687	death certifica ne attending pl ed for use as t	Physician/Me	III the past 12 Illumins	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
B.	the de by the	hysi	1 Yes 2 No 4 Pregnant 9 Unknown 9 Unknown						
Division of Vital Records, P.O.	is that the death certifica igned by the attending pl be detached for use as t	by	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause give	en in Part I.			to the cause of death?
rds,	requires been sign should b	ted					1 Tes	s 2.2 No 3□	Probably 4 🗌 Unknown
000	has b je 2 sł	Completed					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
Ä	nysician: The law inscertificate has build director, page 2 s		25. Was case referred to medical		00 File	(D. # 60 /	1 🗆 Yes 2	No 1 Ye	es 2 No
Vita	ysicia is cert direct	To Be	examiner?	tient 2 - ER/Outpatie	Othor	ce of Death (Check		ice 6 Other (Spe	oife)
of	ng Phys fter this ineral di		27. Manner of Death ★ Natural 5 Pending (Month, D	ury 28b. Time o		at 2	8d. Describe how		City)
ion	I or Attending after death. Director: After I in by the fune	Certificate:	2 Accident Investigation		M 1 □ Y	′es 2 □ No			
ivis	Il or A after Direc d in by		4 Homicide determined 28e. Place of Ir building, 6	ijury - At home, farm, str tc. (Specify)	eet, factory, office	2	8f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
	To the Hospital or Attending Physician: The law requires that the within 44 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier 1 Certifying Physician: To the best	of my knowledge, death	occurred at the time,	date and place, an	d due to the caus	e(s) and manner as s	stated.
	the H		(Check 2 Medical Examiner: On the basis of only one) 3 Certifying Nurse Practitioner: To	examination and/or inves he best of my knowledge	, death occurred at the	e time, date and plac	the time, date and be, and due to the	place, and due to the cause(s) and manner	cause(s) and manner stated. as stated.
	6 8 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		29b. Signature and title of certifier		29c. License r		290	d. Date signed (Mon	th, Day, Year)
			30. Name and address of person who completed cause of						
			KAREN NATER-PI	NEIRO	22 5	. Ereene	St Ba	Itimore 1	40 21201
	Stat Registra	e	31. Date filed (Month; Day, Year) APR 1 9 2012	rar's Signature	west .				
	negistra		AFR I 9 ZUIZ	- 1-17					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Paul Rosenthal		amend 1- For State Registrar	"State	of Maryla	áńa /1	Départin Certific			nd Men	ital Hy		eg. No	20		2	1224
Physiciar Medical Examin	n/	Decedent's Name (Firs Paul Jose Ro		· ·						2	Date of Dea Month	Day	Year		3. Time o	
		4a. Facility Name (if not in			ımber)		4	o. City, Town, o	r Location	of Death	April 16, 2		c. County of I	Death	1207	
		3925 Beech Ave						Baltimore								
Funeral Director		5. Social Security Number	1X	ex M 2 F		In yrs. last bir	Yrs.	If Under 1 Yea Months Day		er 24Hrs. Min.	8. Date of Bir	19 2 01 2	PPYYYY) S	oreign	nplace (Sintry) S	
any	ł	Usual Residence of Dece 10a. State 10b. 0	dent County		10	Oc. City, Town	or Location	n	<u> </u>					\neg	10d. Insid	de City Limits
E	6	Maryland (-			Baltin	nore								1 XXY	es 2 No
with the Maryland 5 23a or 28a-f show s 10tified at once.	Director	10e. Street and Number 3925 Beech Ave	enue An	t 521				10f. Zip Code 21211				-	izen of What ted Stat		try?	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatite event, the Medical Examiner must be notified at once.	Funeral D	11. Marital Status	Y Married	12. Was Dec		ver in U.S.		Decedent of Hi	ispanic Orig		cify Yes or No		14. Race - A White, e	Americ	an Indian	, Black,
iter dea		3 Widowed 4		1 Yes	² XX	No	1	Yes 2 X No	specify:				Specify:	Whi	te	
ours af	ğ	15. Decedent's Education		or Dates:		eted) 16a.	Decedent	s Usual Occupa st of working life	ation (Give	kind of wo			Kind of Busin	ess/Ir	ndustry	
36 in 72 h in 72 h in an "r	pleted	Elementary/Secondary	(0-12)	College (1	-4 or 5+)			resident	s. DO 1401	use reme	u)	1	Transpor Trucking		-	-
215-0036 be filed within 7 tral Hygiene. *ked other than ent, the Medica	5 5	17. Father's Name (First,	Middle, Last	-			vice i	resident	18.Mother	's Name (I	First, Middle, M			, Aun	erica	-
1218 d be fill ental H arked	8	Arthur Rosent									ıl-Marti					
MD 21; d 2 should the and Men and 27 is martic even	2	19a. Informant's Name/Re Barbara Tang						Address (Stree ech Avenu					ity or Town, s 21211		Zip Code	,
G, N 1 and 2 Health Fitem 3	ŀ	20a. Method of Disposition	n	· ·		20b. Place		on (Name of ce			Date		Location - Ci		own, Sta	ie
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 X Cre 4 Donation 5 0	ther Specify	:	om State	Atlant	ic Cre	natory			17,2012					
Balt permit. Depart Import		21. Signature of Funeral S	Service Licer	nsee			22. Na 3631	me and Addres Falls Ro	s of Facility oad, Ba	Burge 1tino	e Henss	Sei and	tz ₁ Eune	ral	Home	Inc.
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														mate Interval n Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b														Death
	Ē															
	edical Examiner	cause. Enter Underlying (Disease or injury that init	Cause iated c.	Due to (or as a	CODSECU	ience of):										
and and recuted		events resulting in death)	Last d.		consequ	161166 617.										
o, be exerting sician a burial -	<u>8</u>	UNPENDED		AMENDED												
Certificate certificate unding physise as the b		IF FEMALE: 3b. Was decedent pregna	ant in the	23c. If yes, o		of pregnancy	Feta	Ideath 3	Ectopic	: pregnanc	:y	23	d. Date of de Month	livery Da	ay	Year
Box 6876 e death certificate the attending phy ed for use as the l	Physician/M	past 12 months?	Unknowr	. '= '		ne of death		r (Specify)							,	
											23e. Did to	bacco	use contribut	e to th	ne cause	of death?
P.O.	9	<u></u>									1 Yes	2 💆	No 3	Proba	ibly 4	Unknown
ords w requi	Completed										24a. Was a					ngs available of cause of
tal Reco	Ę										perfor		deat	th? Yes	. 2	! No
ital strain:	8	25. Was case referred to r examiner?	Ţ.	lospital:	npatient	2 T EB/O	utpatient		of Death (Posido	ence 6 🗸 ()thor	Saana	
of Vision Physical After this Uneral divi	<u></u>	1 Yes 2 N 27. Manner of Death	lo	28a. Date		28b.	Time of Inj		ıry at Work		Bd. Describe h			mer:	Scene	
ion ttendin leath. ftor: A		1 V Natural 5 2 Accident	Pending Investigati		Day, real)	, l		1	Yes 2	No						
Division of Vital Records, tall or Attending Physician: The law required and redeath. To Director: After this certificate has been sided in by the funeral director, page 2 should be a second the funeral director.	Certification:	3 Suicide 6	Could not determine	be 28e. Place	of Injury	y - At home, fa	ırm, street,	factory, office b	ouilding, etc	c. 28	or Town, S		ind Number o	r Rura	al Route N	lumber, City
y fill bu bi		29a. Certifier 1 Certify		ian: To the bes		-										
To To com	Medical	411	certifier	and manner st		1-0	<i>a</i>	29c. Licens					Date signed			ar)
		Julo 4	Me	-Ve		300	<i>v</i>	O.C.	M.E.			Apr	il 16, 2012	?		
0		30. Name and address of p Victor Weedn MD		completed caus ssistant Med		,	900 W.	Baltimore S	Street, Ba	altimore	, MD 2122	:3				
Stat Registra	te ar	31. Date filed (Month, Day APR 192	Year)	32. Re	gistrar's	Signature	. 6	-					_			
DHMH 17 Rev 1/200		0 4	OCIME		10.	OR	IGINAL									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 12242 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:47PM Garrett P. 2012 Rhea Medical Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c County of Death uare 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Min. (Month, Day, Year) 6/13/1935 **Director** Yrs 76 415-52-8516 Tennëssee Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Baltimore <u>Middle River</u> ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be Funeral 21220 31 Compass Road S. A. Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. ģ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Completed 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Operator Technician Cosmetic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev anne. Louis Rhea Margaret Trent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Michael Rhea (Son) 3707 Swift Run Court Maryland 21009 Abinadon. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 2672 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard. Middle River, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility PA Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year ☐ Pregnant at time of death☐ Unknown cate has been signed by the a page 2 should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 No 1 Yes funeral director, 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? (0 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No the f Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State Medical 1 Secritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 1016801 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) renkla Square Br. Balto MD 21257

State

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

20^{Year}2

5:40 PM

9. Birthplace (State or Foreign

10d. Inside City Limits 1 X Yes 2 No

Country) New York

White

Approximate erval Between

Onset and Death

Year

death?

2 🗌 No

For State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 15^{ay} Ida Ann Ross Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Spring House Bethesda Montgomery 5. Social Security Number If Under 1 Year 6. Sex **Funeral** 7. Age (In yrs, last birthday) If Under 24 Hrs. 8. Date of Birth 1 M 2 St F 82 Days Hours Now 17, 7 ay, 1822 9 **Director** 131-20-5039 Usual Residence of Decedent or 28a-f shov within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 10a. State 10b. County 10c. City, Town or Location MD Montgomery Bethesda 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral [4925 Battery Lane Unit 304 20814 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 X Married Yes 2 V No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home be filed v Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic Louis Gentile Maria Cristina Salvia 19a. Informant's Name/Relationship (Type, Print) 19b Majling Address (Street and Number or Rural Route Number City or Town State, Zip Code)
45 Majling Address (Street and Number or Rural Route Number City or Town State, Zip Code)
Washington, DC 2008 Washington, Richard M. Ross 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) St. Charles Cemetery 04-20-12 Farmingdale, NY 22. Name and Address of Facility Metropolitan Funeral Service 21. Signature of Fun al Service Licensee 5517 Vine Street, Alexandria, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sici_n 4014 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month by the Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? Completed by 2 ♣No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has l autopsy performed this certificate Yes 2 25. Was case referred to examiner? funeral director, Be 26. Place of Deat A heck only one) Hospital Other 1 🗌 Yes 2 No ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manne of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 \square Pending work 1 Tyes 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my Inowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature a

State Registrar

Month, Day, Year,

APR 19

DHMH 17 Rev 7/2009

An LANE #2036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Year APRTL 14 2:45A BETTY ELLEN RHODES Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Min. Hours Director 79 Yrs. 220-28-6375 1 □ M 2 **X** F Virginia 03/29/1933 ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 TV No NC Lenoir La Grange 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2453 Sutton Loop Road 28551 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. "natural", or Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Specify: White Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. 12 <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Howard Saunders Dixie Grav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 1 and 2 s of Health s item 27 i Frances Burdette - Daughter 524 West B Street, Brunswick, MD 21716 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Pinelawn Memorial Park 4-19-2012 4 ☐ Donation 5 ☐ Other (Specify) Kinston, 22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine Street, Alexandria, VA 22310 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed andiamy burial-tran resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the IE FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Month Year 1 Yes 2 No 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed / death? certificate 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Hospita 1 Yes 2 X No Other: မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 Yes Accident Investigation 6 Could not be the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely 29b. Signature and title of certifier

State Registrar PRATIMA PANDEY
31. Date filed (Month, Day, Year)
32

30. Name and address of person who com



leted cause of death (Item 23a) (Type, Print)

4-16-2012

12-02905

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Richard Anton F	Rova	State of Maryland / Departme		vaiene								
1- For State Registrar Certificate of Death Reg. No. 2012 1224												
Physici	an/	Decedent's Name (First, Middle,Last)	1	Date of Death Time of Death								
Medical Exam	iner	Kichard Anton Koya		Month Day Year 2201 hrs								
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Glen Burnie	4c. County of Death								
Funeral		1501 Dorsey Road 5. Social Security Number		Anne Arundel 8. B. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or								
Funera! Director			Months Days Hours Mir	16								
		2 3 - 43 - 7055 1 2 M 2 F 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T	Yrs.	THUS IX, 17H4 COUNTY MD								
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Aaryk 28a-f 1 at o	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?								
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho maric event, the Medical Examiner must be notified at once.		8250 Carters Lik	21108	usa								
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On tendir eath.	흝	1 Natural 5 Pending FOUND: FOUND: FOUND 2 Accident Investigation Apr 13, 2012 FOUND		Subject hanged self								
	ertification:	Z Accident investigation	n, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Divisi spital or At nours after d neral Direct	Cert	4 Homicide determined (Specify) Other (specify)		1501 Dorsey Road, Glen Burnie, MD								
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To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or invariant and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)								
	-	O 1 1'-	O.C.M.E.	April 14, 2012								
72		20 Name and address of party	O.O.WI.E.	/WIII 14, 2012								
DMC		 Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 	W. Baltimore Street. Baltimore.	MD 21223								
S	ate											
Regis		31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature	With the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of t									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Julia Estelle Rich 04/06/2012 12:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University of Maryland Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours 02/28/1946 214-48-9119 **Director** 1 □ M 2**X** F 66 MD Usual Residence of Decedent 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ms 23a or 12305 Richwood Drive 21740 USA items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ö 1 Yes 2 X No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. White "natural", Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk 12 other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev P Braxton Rudolph Mary Frances Seebold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Duff Daughter 12305 Richwood Drive Hagerstown MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4/11/2012 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crem 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Signature of Funeral Service Licensee ThomasAllenPA 7090 Ridge Rd Hanover MD Part⁴. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Pulmonary Hypertension 3yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami that the death certificate be executed Scleroderma 6yrs Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 1 Yes 2 X No 9 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Acute on chronic kidney disease, Hypertension Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Coronary Artery Disease 24a. Was an has autopsy page performed? certificate 1 Yes 2**X** No Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 X No ျ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural 5 Pending 1 Yes I Director: A ed in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

State Registrar 31. Date filed (Month 9 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Christopher End 22 South Greene Street Baltimore MD 21201

D 73731

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State	of Mar	yland			nt of H e <i>of D</i>		and M	lental Hy	_	00	10	1	221.
			Registrar 1. Decedent's Nam	e (First, Middle, L	ast)			007	mean	0, 0	- Cati		2. Date of De			16	3. Tin	ne of Death
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and the second	Funeral		5. Social Security N		Sex		yrs. last		If Unde	r 1 Year	If Under	24 Hrs.	8. Date of Bi	rth		9. Birthp	lace (St	ate or Foreign
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Division of Vital Records,	: The law r cate has b ; page 2 sl	Completed											perf	opsy ormed?	pri de	or to cor ath?	npletion	ings available n of cause of
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<u> </u>	lor At after o Direct	Cert	4 Homicide	determine	28e. Plac	e of Injury ling, etc. (S	- At home Spec <i>ify)</i>	e, farm, stre	et, factor	y, office			28f. Location City or To	Street a wn, Stat	nd Number e)	or Rural	Route I	Number,
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	30,		30. Name and add	ress of person wh	o completed cau	se of deat	th (Item 2)	3a) (Type, P ROLL	rint) AV£	NUE.	TAK	com.	A PAR	K,	mo:	209	12	
	Sta		31. Date filed (Mon	th, Day, Year)		Registrar's			,	- (_			•				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8:55 2M **Physician** APT. 2012 Edwin John Sterner /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Manchester Longuica Mussing Home Coursoil If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year QL Months 1 X M 2 ☐ F 220-16-3513 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a, State 10b. County a or 28a-f show t be notified at Westminster 1 ☐ Yes 2 No MD Carroll Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 2 and 10 marked other than "matural", or other traumatic event, the Medical Examiner must he mone. 14:11 21158 4622 Band Hall USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: white Baltimore, Maryland 21215-0036 A Q 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farming -acmer 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha M. Wildasin John William Sterner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4622 Band Hall Hill Kd., Westminster, MD 21158 Klinedinst Donald 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. Bartholomew Cem. Apr. 21,2012 Hanover, AA 22. Name and Address of Facility Wetzer Fun 2500 Signatur / f Funeral Service License Home and Clematery, Im., 549 Curtiste St. Honores, PA 7331 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final disease or condition resulting in death) Physician week /Medical Due to (or as a consequence of): Examiner Vascular disdaso Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: A Nursing Home 5 Residence 6 Other (Specify) 1 Yes 27 No Certification: To 28a. Date of Injury (Month, Day Year) 28h. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital within 24 hours all To the Funeral Completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 037573 8,2012

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed

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S. park

cause of death (Item 23a) (Type, Print)

Battimo-e

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ April 14, 6:30 Michael Skasko Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day,) May 18, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 🕱 M 2 🗆 F 80 166-26-1573 Pennsylvania Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Montgomery Village MD Montgomery 10f. Zip Code 10e. Street and Numbe 10g, Citizen of What Country? Funeral 10059 Maple Leaf Drive 20886 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 2 X No 1 Yes If Yes, Give 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates ed other than "natu 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2121 Social Security Elementary/Seconday (0-12) College (1-4 or 5+) 12 Manager Administration is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) and Mental Michael Skasko Mary Sheftic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trat 10059 Maple Leaf Dr., Montgomery Village, MD 20886 Marie Skasko Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State st. Mary Cemetery 1 X Burial 2 Cremation 3 Removal from State 04-20-2012 4 Donation 5 Other (Specify) Jenner, PA 22. Name and Address of FacilityMetropolitan Funeral Service 21. Signature of Fureral Service Licens 5517 Vine Street, Alexandria, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIFC Due to (or as a consequent ARRHYTHMIA Physician/ disease or condition Medical resulting in death) as a consequence of) Examiner cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine . METAST ATIC ADENOCARCINOMA Physician: The law requires that the death certificate be executed physician and sthe burial-transi resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 📉 No Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 A Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No. မ 1 ♣ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \(\sum_{\text{Nursing Home}}\) Nursing Home 5 \(\sum_{\text{Residence}}\) Residence 6 \(\sum_{\text{Other}}\) Other (Specify) this (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) D00644 April 15, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Or Rockville Md 20850 VTehari 1099 State 19

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ADY 10:07PM 2012 Medical Eacility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner awsor altimore tos pice 8. Date of Birth (Month, Day, Year) Security Number Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Sex **Funeral** Min. L-96Z Country) **Director** 1 🗆 M 2 🖪 حاحا Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland be notified at Director 1 Nes 2 No of the more 10g. Citizen of What Country? Completed by Funeral 21208 **Examiner must** , or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cubar, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 12. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Black If Yes. Give "natural" 3 Widowed 4 □ Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) traumatic event, the urveyor and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည . Page 1 and 2 should be f ment of Health and Menta ames 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru ral Route Number, City or Town, State, Zip Code, item 27 7400) 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Aurial 2 Cremation 3 Removal, from State 4 Donation 5 Other (Specify) 21. Sign three Funeral Service Chense 22. Name and Address of Facility towell any ight 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as Ardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_i_i_i_n/ disease or condition resulting in death) tastalio Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed page 2 🗆 No Yes 2 1 1 Yes 25. Was case referred to medical completely filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 700 မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending injury Accident Investigation 1 Yes 2 No 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and the of certifier

31. Date filed (Month, Day, Year,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Si

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29c. License number

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29d. Date signed (Month, Day, Year)

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BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland /				lental Hyg	jiene			
		State Registrar	Certificate of Death				Reg. No. 2012 12251			
Physicia		Decedent's Name (First, Middle, Last) RUTH SOLOMON				2. Date of Death Month Day Year APRIL 15 2012				
Medi Examir		RUTH 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death				4c. County of Death				
<i></i>		1604 WOODLING WAY		BALTIMOR				TIMORE		
Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	Date of Birth (Month, Day,		9. Birthpl Counti	lace (State or Foreign ry)	
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e, N and 2 Health em 27 ther tr		GILBERT SOLOMON/HUSBAND 20a. Method of Disposition 20b. Place		NAPA RIDO				-		
<u> </u>		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Hy, JA	sition <i>(Name of</i> LOB <u>—</u> ESHEAR	0//1	- 1	20c. Location - C	•		
Baltimor permit. Page 1 Department of Important: If if any injury or o		21. Signature of Funeral Service Licensee		ESHEAR Name and Address		7/2012 LEVINS	ROSED.			
		8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate							MD 21208	
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Medical Examiner		resulting in death) Due to (or as a consequence	a consequence of):							
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ital or /		4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
DIVISION OF VITAL Red To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
To wit		29b. Signature and title of certifier Patricia Abardulus 29c. License number \$\frac{1}{2}\tau \tau \tau \tau \tau \tau \tau \tau					29d. Date signed (Month, Day, Year) 4 16 2012			
		Patricia Abandulus D27209 4/16/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10755 PALLS READ SUITE 200 LUTHERVILLE, MD 21093								
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	ules							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ()4 Physician/ 2012 John 2:47 PM Smith Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Hospital Baltimore Bon Secours N/ASocial Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 🕅 M 2 🗆 F 214-56-9452 0970971952 59 S. Carolina Director Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 XYes 2 No Baltimore MD N/A 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be Funeral 23a 724 N. Monroe St. items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Medical Examiner Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. ö ò 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced Black Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) 11th Grade College (1-4 or 5+) Linen Service Manor Care event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ည Samuel Leroy SMith Eartha Lee Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Helen Hair(sister) 7713 Janel Lane, Baltimore, MD 21236 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Department o Important: If any injury or once. injury or 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Park 04/19/12 Baltimore, MD 21. Signature of Funeral Service Licer ²² Name and Address of Facility Joseph H. Brown Jr. Funeral Home PA 2140 N. FUlton Ave., Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Hypoglycemia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Day Month Year Yes 2 No been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus, Hepatitis C Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? after death.

Director: After this certificate 2 🗌 No 1 Yes Yes or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes 2 3 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and little of certific

Registrar

DHMH 17 Rev 7/2009

State

St.

Physician

Presiden

32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vora

9 2012

31. Date filed (Month, Day, Year)

D73195

Unt 1504, Baltimere, MD 21202.

04, 12, 2012.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1, per PHY, 17, per fn, g928 6-13-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Claude Benjamin Trevey 2. Date of Death 3. Time of Death Physician/ APRIL 12.23 AM 12 Claude Benjamin Trevy 2012 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death N/A **Examiner** 4b. City. Town, or Location of Death SINAI HOSPITAL BALTIMORE OF BALTIMORE 7. Age (In yrs. last birthday) lf Under If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** i. Social Security Number 218-30-3328 Months Hours Min. (Month, Day, Year) **Director** 1**X** M 2 □ F 05/26/1934 Washington DC 77 or 28a-f show with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Owings Mills 1 🗌 Yes 2 🔀 No Baltimore Co. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a U.S.A. 21117 400 Granleigh Ct. permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. rmed Forces?

Yes 2 No
Yes, Give 11. Marital Status 14. Race - American Indian Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) nentary/Secondary (0-12) College (1-4 or 5+) N/A Disable 12th Grade Be 7. Father's Name (First, Middle, Last)
John Malcolm Trevey
John Malcolm Trevy 18. Mother's Name (First, Middle, Maiden Surname) မ Phyllis Marie Reed 19a. Informant's Name/Relationship (Type, Print) Cousin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeannene S. Stottlemyer Box 1201 Hedgesville, W. VA 25427 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State on-site Crematory 04/18/12 Baltimore, MD 4 Donation 5 Other (Specify) 21, Sign and I Juneral Service License 力の智管はMathessの哲学でwn Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CVA Ph_{sician}/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 Pregnant at time of death
9 Unknown Month Day Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? 2 🗌 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 2 🗹 No Other: 1 🗌 Yes N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) 23768 APRIL 12 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OF BALTIMORE, 2401 W.BEVEDERE AVE, BALTIMORE, MD 21215 PUSHAPPORP BRAK, M.D., SINAL HOSPITAL 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 8 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 8^{Day} Physician/ APRTL 20°12 2130 GEORGE D. TOUKOLON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** -8891 Days Hours 6 18 7 19 4 4 LISERIA **Director** 67 Yrs. 1XXM 2 - F at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo ms 23a or 28a-f s must be notified PRINCE GEORGE' MD s CHEVERLY 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20785 6117 MONTROSE RD UNITED STATES "natural", or items dical Examiner mu death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) CORRECTIONAL OFFICER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ DAVID TOUKOLON YEA TOUKOLON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6117 MONTOSE RD., CHEVERLY, MD. PHILOMENA TOUKOLON/WIFE 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 HARMONY MEMORIAL 4/21/2012 LANDOVER, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Funeral Service Lice MARYLAND AVE NE WASH., DC 20002 1425 23a. P. f. 1. Enter the disease, or or implications that called the death. I hot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? signed by the atte d be detached for Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has autopsy performe 1 Yes 2 No Yes 2 X No Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🕱 No Other: ည 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 No M 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practitioner To the best of my knowledge, owatted at the time, date and place, and due to the 29b. Signature and title of certifier 29c. License number D63688 10,2012 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 3001 HOSPITAL DR. CHEVERLY, MD 20785

Registrar DHMH 17 Rev 06-2011

State

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31. Date filed (Month

DAVIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 2<u>012</u> Physician/ Month March 29 7:20 AM M <u>Virginia Whittlesev</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 1 - M 2 F 216-46-1921 Dec 25, 1921 Maryland 90 show 10a. State at 10c. City, Town or Location Director or 28a-f sh notified 1 Yes 2 X No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? à ral", or items 23a or Examiner must be Funeral 21204 1055 W. Joppa Road USA permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: white "natural" 3X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ed other than ' event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 teacher education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H 27 is marked of r traumatic ever 0 John Theodore King Charlotte Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Markell Whittlesey/son 2901 Boston Street #319 Baltimore, MD of Health item 27 other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, - 5 Department o Important: If any injury or once. 4 X Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street onal Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, onheart failure. List only one cause on each line. Approximate Interval Retween O et and De Immediate Cause (Final Ptrysician/ disease or condition resulting in death) SCHEMIC Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregp 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy5 Other (specify) ō in the past 12 month Month Year Pregnant at time of death Day 1 ☐ Yes ∠ ₹ 9 ☐ Unknown Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ATRIAL FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown PERIPHERAL VASCULAR DISCASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed? 2 3 No 1 Yes Yes 2 funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2. 40 ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 other (Specify) After this 27. Manner Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 24 hours after death.
Funeral Director: After 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29a. Certifier

29b. Signature and title of certifier

DHMH 17 Rev 06-2011

within 24 hou

To the Funer

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ nnis & WRIGH 1129 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore** Halethorpe 5520 Carville Avenue . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Days Min Hours 1**⊠**M 2□F 59 Director 218-60-5024 10/28/52 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Halethorpe MD Baltimore 10e Street and Number 10g. Citizen of What Country? items 23a or ner must be r Funeral 21227 5520 Carville Avenue 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ö by 1 X Never Married 2 Married within 72 hours after 1 Yes 2 No Specify. Specify: "natural", Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Meat Cutter Sava1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever ဂ Anna Marie Russell Dennis Edward Wright Sr. of Health and Mer fitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna M. Wright / Mother 5520 Carville Avenue Halethorpe, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Department c Important: If any injury or ō Loudon Park Cemetery | 4/19/12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licens Cer 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ -1 we disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, Be (Was case referred to medical 26. Place of Death (Check only one) Hospital 2**/2** No 1 Inpatient 2 ER/Outpatient 3 IDOA မ 1 Yes 4 Nursing Home 5X Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? injury Matural 🎾 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6934

Registrar
DHMH 17 Rev 06-2011

State

Maryland 21215-0036

Baltimore,

Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:45 A M Ruby Whalev April Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Manor Care Health Services Rossville <u>Baltimore</u> 7. Age (In yrs. last birthday) Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Country) 408 36 2105 **Director** 1 □ M 2 🛚 F 86 03/06/1926 Tennessee Usual Residence of Decedent 28a-f show 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Middle River 1 Yes 2 X No Maryland Baltimore ۵ 10e. Street and Number 10g. Citizen of What Country? Funeral 22 Left Aileron Street 21220 United States . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify White 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marshall Richards Mattie Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Gable (daughter) If item 27 22 Left Aileron Street Middle River Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If is
any injury or or Burial 2 Cremation 3 Removal from State Holly Hill Mem Garden's 4/19/2012 Baltimore County, Md. 4 Donation 5 Other (Specify) on Funeral Service Lic 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 old Eastern Avenue Es 21. Signa Essex, Maryland 21221 23a. Parl 1. Enter the disease, shook, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death heart failure. List only one cause on Physician/ Medical Due to (or as a consequence of): imers Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown P.0. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 -Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 2 X No 1 Yes Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year, 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. 1 XNatural 5 Pending safter death.

I Director: After din by the fur Division 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier 🛮 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 17-2012 D0073005 Woods 12a Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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31. Date filed (Month)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 12258 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MARGARET 2012 WEIDNER 505 ARCII Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Cent Anne 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday, Funeral 216 28 2114 Director 1 □ M 2🛣 F 80 Maryland 02/13/1932 Usual Residence of Dece 28a-f show 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Anne Arundel Glen Burnie 1 Yes 2X No or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Medical Examiner must be Funeral 23a 117 Alview Terrace 21061 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ō þ 1 Never Married 2 Married 1 Yes 2X If Yes, Give Year or Dates Saltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X☐ No Specify "natural" Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Line Operator 12th Calvert Dist. Department of Health and Mental Hygin Important: If item 27 is marked other any injury or other traumatic event, to once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas L. Totten Lina V. Fant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Totten / Niece 8603 Wintergreen Ct. #401 Odenton, Maryland 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town. State 1 X Burial 2 Cremation 3 Removal from State MD State Veteran Cem. 04/23/2012 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. manu 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Sepsis disease or condition resulting in death) WEEK Medical Due to (or a) a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 687600 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? be detached for Month Day Year Pregnant at time of death 1 Yes 2 Unknown the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an the Hospital or Attending Physician: The law thin 24 hours after death.

• the Funeral Director. After this certificate has I ompletely filled in by the funeral director, page 2 s autopsy 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 🔀 No Hospital Other: မ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D64307 MD 2012 . Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DAVID

Date filed (Month, Day, Year)

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Frad BueniF

MD

20161

Division of Vital Records, P.O. Box 68760

	•	For State Registrar		State of	Maryland		artment o tificate o		and M	lental Hy	giene Reg. No	201	2	12259
Physicia	n/	1. Decedent's Name (Firs	,	Vend	1011	\ \	(2 m)	011		2. Date of De				ime of Death
Medic Examin		4a. Facility Name (if not in	nstitution, give str	eet and numbe	er)	V V	4b. City, Town	, or Location	of Death	April	2:20 AM			
Funeral	H	Sinai Ho 5. Social Security Number		-	Age (In yrs. las		Bau If Under 1 Ye	HM6	r 24 Hrs.	8. Date of Bir	th	N/	A dhalass "	State on Fernice
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with the Maryland \$ 23a or 28a-f shoust be notified at	Direc	10e. Street and Number	NIF	}	J B	altr	10f. Zip Cod							Ves 2 □ No
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of Health of Health fitem 27		20a. Method of Disposition		OI I	20b. Pla		sition (Name of atom or other p	JWCCC	<i>j</i>	ate /	20c. L	ocation - City or	Town, St.	
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Attencer death	Certificate:	2 ☐ Accident 3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Investigation Could not be determined	28e. Place of	Injury - At hom	e, farm, stree		Yes 2				d Number or Ru	ral Route	Number,
pital or burs afte eral Dir filled in		20a Cartiflar 1 X Co	and if time Diversity		etc. (Specify)	1				City or Tow				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 L M	ertifying Physicia edical Examiner ertifying Nurse P	: On t he basis o	of examination a	ind/or investig	ation, in my opi	nion, death o	ccurred at the	he time, date a	nd place.	and due to the	cause(s) ar	nd manner stated.
To To Con		29b. Signature and title of RTM e	Certifier WZ	M·D.	-			se number	3			te signed (Month		
Um	-	30. Name and address of	person who com	pleted cause o	f death (Item 2	3a) (Type, Pri	nt)							
State			Neuta,	Sina I	HOSPI	tal (of Bai	hmo	re,	2401	W. E	Belvede.	MD	2/2/5
Registra		APR	Year) 1 9 2012	Lexu	m A.	par	Ke							
/H 17 Rev 06-20				_										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Geraldine Patricia Znamirowski 18 2012 April Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death RUCTI MORE 9629 Dundawan Road Nottingham 5. Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland 1 🗆 M 2 🏻 I 212 50 0350 (Month, Day, Year) 03/26/1948 Months Days Hours 64 **Director** Jsual Residence of Decedent . 23a or 28a-f show ust be notified at should be filed within 72 hours after death with the Maryland and Mental Hyglene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Nottingham 1 🗆 Yes 2 😿 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral er than "natural", or items 23 the Medical Examiner must 9629 Dundawan Road 21236 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🔀 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) onday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Laura Mary Blaszak 1 and 2 should be if Health and Menta item 27 is marked other traumatic e Edward Lejk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Znamirowski / Husband 9629 Dundawan Road Nottingham, Maryland 21236 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State Holy Rosary Cemetery 04/21/2012 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. manunaler 4001 Ritchie Highway Baltimore, Maryland 21225 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Opset and Death Immediate Cause (Final Physician/ EREBROURSCULAR disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 menths?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 1 Residence 6 Other (Specify) 1 ☐ Yes 2 V No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at After 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deatl 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 04-18-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Christopher Zajac,

MD

32. Registrar's Sig ature

9649 Belair Road

Perry Hall, Maryland 21236

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Joseph James Zoo	1- FOR State	#11State of Ma	ifyland ≯be C	partment	of Health an of Death	id Mental F		eg. No. 20	112 1226			
Physician/ Medical Examine	1. Decedent's Name (I		S ZOOK	ζ			2. Date of Deat Month April 7, 20	th Day Year	3. Time of Death 0923 hrs			
Marie Control		ot institution, give street a			4b. City, Town, or Leonardtov	r Location of Deat Vn		4c. County of I	Death			
Funeral Director	5. Social Security Num 216-42-6	003 1KM 2		s. last birthday) 7	If Under 1 Year Months Day		_		9. Birthplace (State or or or or or or or or or or or or or			
Ow any	Usual Residence of De 10a. State 10i MD	ecedent b. County ST. MARY		ity, Town or Loc					10d. Inside City Limits			
the Maryland n or 28a-f sh tiffed at once	10e. Street and Number			CHARI	JOTTE HA 10f. Zip Code 206		10		Country?			
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married	12. Wa	s Decedent Ever in ed Forces?	H	Vas Decedent of His Yes, specify Cubar	spanic Origin? (S		14. Race - A	American Indian, Black,			
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Baltimore, pernit. Pages 1 an Department of Hee Important: If ite injury or other tr	4 Donation 5 21. Signature of Forer			22	V CREMAT	s of Facility						
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transiedical Certification: To Be Completed by Physician/Medical E.	IF FEMALE: 23b. Was decedent pre- past 12 months? 1 Yes 2 No 9	gnant in the 1 L	yes, outcome of pre live birth Pregnant at time of Inknown	2 _ F	Fetal death 3 Other (Specify)	Ectopic pregna	ancy					
S, P.O. nires that the signed by the detached by the detached by P.D. ad by P.D. ad by P.D. ad by P.D. and by P.D.	Part II. Other significa Chronic Alcoh		ing to death but no	t resulting in the	underlying cause g	given in Part I.	1 Yes	2 No 3	Probably 4 Unknown			
Division of Vital Records, P.O. B tal or Attending Physician: The law requires that the d are after death. **In Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached ertification: To Be Completed by Phy	25 Man and artered	to modical			OC Please	of Death (Obselve	1 Yes 2	sy prior	to completion of cause of			
Vital hysician this certi	25. Was case referred examiner? 1 ✓ Yes 2	No Hospital: 1	Inpatient 2	✓ ER/Outpatie		of Death (Check Other Nursin		Residence 6 C	Other:			
vision of Vi or Attending Physi for death. Director: After this in by the funeral dir iffication: To	27. Manner of Death 1 ✓ Natural 5 2 Accident	28a. (Date of Injury Month, Day,Year)	28b. Time of		ry at Work? Yes 2 No	28d. Describe ho	ow injury occurred				
Division or To the Hospital or Attending, within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune- ledical Certification:	3 Suicide 6 4 Homicide	determined (Spe	cify)		eet, factory, office b		or Town, St	ate)	r Rural Route Number, City			
To the Ho within 24 F To the Fun completely	(Check only					, death occurred a			to the cause(s)			
	30. Name and address	ferson who completed	cause of death (Ite	em 23a)	O.C.I	M.E.		April 8, 2012				
	Laron Locke M	ID. Assistant Med	dical Examiner	900 W. E	Baltimore Stree	t, Baltimore, I	MD 21223					
State Registrar	31. Date filed (Month, D	0 2012 33	2. Registrar's Signa	ture	1							
DHMH 17 Rev 1/2001 0 CME 2006	HT IL	OSME		ORIGIN	AL.							

Physician Examiner Box 68760 P.0. Records, Division or Vital

requires that the death certificate be executed and burial-tran attending physician To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

Physician

/Medical

Examiner

10a. State

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Director

Funeral

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Completed

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Director

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permit. Pages 1 and 2 should be filed with Department of Health and Mental Hyglen. Important: If item 27 is marked other that any Injury or other traumatic event, the konce.

/Medical

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Maryland 21215-0036

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Examine

3 ☐ Suicide 4 ☐ Homicide 29a, Certifier (Check only one)

6 ☐ Could not be

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

pain H- WOLDETHING

29c. License number D0063327 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GIZAW WOLDEHINDT, MD 2434 W. BELVEDERE AVE, BALTIMORE, MD

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ori Medical cility Name (if not institution, give street and number) Examiner City, Town, or Location of Death County of Death 9. Birthplace (State or Foreign Country) New Jersey 7. Age (In vrs. last birthday If Unde **Funeral** 4 Hrs. 8. Date of Birth Months Days Min June 13, 1 ☐M 2 [X] F Year 92.8 22-0594 Yrs Director 83 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Adamstown 1 Tes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? event, the Medical Examiner must be 23a Funeral 3209 Buttercup Court 21710 USA items ; 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc ò by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Building Design 12 4 Architect Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Lockwood Loftus John Nora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Mark/daughter Saratoga Springs Court, Middletown, MD 21769 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 4 ☐ Dopation 5 ☐ Other cemetery, crematory or other place) From State Apr.14,2012 Dunmore, Pennsylvania Dunmore Cemetery 504 Main Street 22. Name and Address of Facility Myersville, MD 21773 Ricketts Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ ina disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Date to for as a por section perch cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tra Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death g ☐ Unknown be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy perforn death? 1 🗌 Yes 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? P Other 1 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending injury work? 1 Yes 2 🗌 No hin 24 hours after death the Funeral Director. completed filled in by the Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within To the 29b. Signature and title of certifier 0 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21784 M 710 Cynthis APR 1 9 2012 32. Registrar's Signature

State

Registrar

1 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 2012 6:42 P M April Lilvan Erb Brewster Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Encore at Turf Valley Ellicott City Howard 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Hours Director 132 16 5494 1 🗆 M 2😿 F 93 Oct 4, 1918 New York Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Howard Ellicott City - 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 4924 Brampton Parkway 21043 United States 72 hours after death . Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 **X**No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 3 ₩ Widowed 4 Divorced Specify: White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Registered Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Erb Emily Muller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Jeffrey C. Brewster/Son PO Box 356 Canton CT 06019 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Ardent Crematory 4-6-2012 4 ☐ Donation 5 ☐ Other (Specify) Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee Frem Collins 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylician ATE STAGE DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CHRONIC DEPRESSIO Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on: or Attending Physician: The law requires that the death certificate be executed FAILURE TO THRIVE and -trar that initiated events Due to (or as a consequence of): resulting in death) Last burial physician Physician/Medical HYPER TENSION Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year 2X No g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has perform Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 1 Yes 2**X** No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify Asstd. 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred eral Director: After filled in by the funer Natural 5 Pending Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature 29d. Date signed (Month, Day, Year) D66493 MARYLAND April 6, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUNSEWE SMITH AV STE 203 BALTIMORE, MD 21209 BABATIDE MD 2835 trar's Signature State Registrar

BREWIN 9+DN

William

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of I	Marylan		artment of H		Mental Hy	giene	201	0	12266
			Registrar 1. Decedent's Name	(First, Middle,	Last)		Cei	tificate of L	Jeath 	2. Date of De	Reg. No	201	4	12266
	Physicia Medi		Barba		uth Beng	tson				Month April	Da	y 201		3. Time of Death
	Examir		4a. Facility Name (if I	not institution,	give street and number)		4b. City, Town, or	Location of Death		4c.	. County of De		18 00
			Salisbury	Rehab	ilitations	Nucs	inactr.	Sali	spuro		(Wice	m	ico
	Funeral Director	п	5. Social Security Nu 003–16–6:		5. Sex 7. / 1 □ M 2 🗶 F	Age (In yrs. Id 84	ast bid hday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 12/03/	th a <i>y, Year)</i>	C	country)	e (State or Foreign
18		1	Usual Residence of [0-4				112/03/	1927		ew I	<u>Hampshire</u>
	yland f sho	호		10b. County			y, Town or Lo						10d.	Inside City Limits
	e Mar 128a- notifie	Director	Maryland 10e. Street and Num	Wicom	ico	Sa	alisbu							1 🖁 Yes 2 🗆 No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral I		vic Ave	•			10f. Zip Code 21804	:		10g. Cit	izen of What C USA	Country'	?
SON	r deat r iter iner n	y Fu	11. Marital Status 1 ☐ Never Marrie		12. Was Decedent Armed Forces 1 Yes 2	t Ever in U.S		Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Am Black, Wh		Indian,
945	s after ral", o Exam	ed by	3 X Widowed 4		1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.	X No	1	☐ Yes 2 🕱 No	Specify:			Specify:	Whi	te
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9 kg	ild be filed Mental Hy iarked oth atic event	ပ	John Mei	se Hugh		sumame)								
Barbara Baltimore, Maryland	d 2 should alth and Me 1 27 is marl er traumati		19a. Informant's Nan Stephen				19b. Mailin 2490	g Address (Street a	nd Number or Run s Wharf 1	al Route Numbe Rd., Ede	er, City or en , N	Town, State, Z 1D 2182	ip Code 22	e)
ore,	e 1 and of Heal If item 3		20a. Method of Dispo		B ☐ Removal from Sta	20b. P	lace of Disposemetery, crem	sition (Name of satory or other place	e)	Date	20c. Lo	cation - City o	r Town,	State
Bar	t. Page tment o rtant: If ijury or		4 Donation	5 Other (Sp	ecify)	Sal	isbury	Cremator	y 4/4/	2012		isbury		
Bal	permit. I Departn Importa any inju once.		21. Signature of Fund	yral Service Lic	Chorryson	_	22 I	Name and Address IOIIOWay IOI Snow	Funeral 1 Hill Rd.	Home Pro	ofess	sional MD 21	Ass .804	ociation
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	ate be executed ohysician and the burial-transit	dical Examiner	resulting in death) La	ast	Due to (or a	s a consequ	ence of):							
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P.O.	that th ned by e detac	y Ph	Part II. Other signific	ant conditions	s contributing to death	but not resu	ılting in the ur	derlying cause give	en in Part I.	23e. Did to	bacco us	se contribute to	o the ca	use of death?
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Division of Vital Records,	al or Att s after d I Direct d in by	Certificate:	4 Homicide	determine	28e. Place of In	jury - At hor tc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tow		Number or Ru	ral Rou	te Number,
	I of the thospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Medical	(Check 2 L	⊔ medicai Exa	hysician: To the best o miner: On the basis of USe Practioner: To the	examination	and/or investig	ration in my opinior	death accurred at	the time date or	ad place	and due to the	naucola) and manner stated.
ļ.	vithir To th comp			e of certifier	os i ractioner. 10 (III	Dost Of HIS	miowiedye, de	29c. License	number			and manner as signed (Monti		Year)
	- A		30. Name and address	s of person who	o completed cause of	death (Item (23a) (Type P		8769		41	2/12	_	
	3TC		Millio a	i Bon	ochila, u	_P	700	Chie	Ave 1	aksbu	1/	rul 2	180	X4
	State Registra	-	AP	R 0 4 20	012 Jahren	rar's Signatu	par	Had						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Beauchamp 3.04 M Elizabeth 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death MEDITAL TENINSULA ROGENAL Vicomica 1 Year If Under 2 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Hours 214-68-6254 1 🗆 M 2 🗓 F 5-13-1957 Maryland 54 Usual Residence of Deced 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🔀 No MD Wicomico Salisbury 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 30064 South Hampton Bridge Road 21804 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Smullen Edna Alfred G. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30064 South Hampton Bridge Road, Salisbury, MD 21804 Stephen Beauchamp - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 XBurial 2 Cremation 3 Removal from State First Baptist Ch Cem. 4-7-2012 Pocomoke City, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) MELAS Syndrome Due to (or as a consequence of) Sequentially list conditions,

Physician Medical **Examiner**

attending physician

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To the Hospital or Attending Physician:

Physician/

Medical

Examiner

Funeral

Director

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3altimore, Maryland 21215-0036

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Examine and -tran Physician/Medical the by Completed page 2 s funeral director, Be မ

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 \square Yes 2 \square No 3 \square Probably 4 \nearrow Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year)

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04/02/12

DHMH 17 Rev 06-2011

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carroll

Registrar's Signata

24.

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APR 0 4 2012

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of M	arylan		irtment of F tificate of L		d Mental Hy		201	2 1	2268		
			Registrar 1. Decedent's Name (First, Middle, Last)		Cel	incate of L	Jeani	2. Date of De				e of Death		
	Physicia Medio		Alton P. Brittingham	Jr.				Month MAICH	20	Year Year		14/AM		
	Examin		4a. Facility Name (if not institution, give street and number)		1	4b. City, Town, or			4	c. County of De		-		
1,000	Funeral		FENINSULA REGIONAL MADIL 5. Social Security Number 6. Sex 7. Ag		est birthday)	If Under 1 Year	1 L/364/	rs. 8. Date of Bi	rth		CMICO irthplace (Stat			
	Director		218-24-5821 1X M 2 🗆 F	83	Yrs.	Months Days	Hours M	in. (Month, Di 11/09/	ay, Year)	0	ountry) Marylar	o o		
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	ath wit ms 23 must	Funeral Director	2313 Hudson Dr. 11. Marital Status 12. Was Decedent E	San in II C	lao v	2180		/O'fVN		USA				
21215-0036	e filed within 72 hours after death with the Maryland trail Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 ▼ If Yes, Give Year or Dates.	No	If	Yes, specify Cuba	n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		14. Race - Am Black, Whi				
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	12 shoalth an 27 is rrtrau		19a. Informant's Name/Relationship (Type, Print) Teresa Cornelius/Daughter					Rural Route Numbe .isbury,			ip Code)			
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	Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):											
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Division of Vital Records, P.O.	s that i gned b	þ	Part II. Other significant conditions contributing to death b	ıt not resu	ulting in the ur	iderlying cause giv	en in Part I.			use contribute t				
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the bask of the column of Certifier Nurse Practition (Total Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of	ny knowle amination	edge, death or and/or investi	gation, in my opinio	n, death occurre	e, and due to the c ed at the time, date a	ause(s) a and place	and manner as s e, and due to the	tated.			
			29b. Signature and title of certifier	~	50	29c. License	number	122	29d. Da	ate signed (Mont	h, Day, Year)			
	77	DM	30. Name and address of person who completed cause of de	eath (Item	23a) (Type_Pr		- H54	127	01-0	1,2				
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		Prince George's Hospital		Cheverly	Location of Dog	tri	Prince Georg					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In 579-23-4794 1⊠ м 2□ F 19	yrs. last birthday) Yrs.	If Under 1 Ye Months Day			rth(MM/DD/YYYY) 9. B 1 9 9 3 Fore h 7 , C	irthplace (State or ign ountry) DC				
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h the h	ΙĐ	601 53rd St SE # 303		20019			U.S.A					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatie event, the Madical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 2 Never Married 1 Never Married 1 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married	No	es, specify Cuba	ispanic Origin? (S in, Mexican, Puert		14. Race - Ame White, etc. Specify: Bla	rican Indian, Black,				
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2		0-~0-		O.C.	M.E		March 29, 2012					
D+ 1		Name and address of person who completed cause of death Donna M. Vincenti, MD		∿ Baltimore	Street, Baltir	more MD 21	223					
St	tate	31. Date filed (Month, Day, Year) 32. Registrar's Si		V. Daimino,	Gliect, Daim	HOIG, NID 2.	223					
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DHMH 17 Rev 1/2001 OCME 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ :40 PM 20/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY THERSBURG 8. Date of Birth Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 212-11-098 **Director** Usual Residence of Decedent 28a-f shov 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** must be notified 1 Yes 2 Au ö 10e. Street and Numbe 10g. Citizen of What Country? 23a KIST items within 72 hours after death 11, Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. traumatic event, the Medical Examiner ò Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced SIAN 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) OWN Be 18. Mother's Name (First, Middle, Maiden Sumame) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26/70 permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. AHMOOD SON 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State FREDERICK 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Mo #1070 BRIDGE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Conges disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transit Cause (Disease or linjury 24 10 and that initiated events resulting in death) Last Due to (or as a n quence of ing physician a e as the burial-Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No ģ Day Pregnant at time of death Month Year signed by the a ld be detached for 1 ∐ Yes ∠ 9 ☐ Unknown Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe iin 24 hours after death.

the Funeral Director: After this certificate I
pleted filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No Other: 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2 5463 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) INTERNAL MEDICINE 65 MD WATKINS MIL Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transi Box 68760. P.0 signed by the a Division of Vital Records, been si should b s certificate has be irector, page 2 s funeral director, this al or Attending F after death. I Director: After d in by the funera After

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Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

/Medical

10a State

To the Hospital of within 24 hours a To the Funeral ID completely

Sequentially list conditions, if any sequentially is in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Disease Osteoarthritis 25. Was case referred to medical 1 Tes 2√2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

29c. License number

10810 Darnestown Road, suite #202, Gaithersburg, Maryland

D19609

29d. Date signed (Month, Day, Year)

April 3, 2012

Registrar

Raman R. Tult, 31. Date filed (Month, Day, Year)

29b. Signature and title of certification

32. Registrar's Signature

M.D. ;

on who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 31, 2012 Physician/ Katharina Anna Elfriede Bhatia March 8:05 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Year) November 23, 1936 Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Days Hours 1 🗆 M 2 🗶 F Director NONE 75 Germany Usual Residence of Decedent shov ral", or items 23a or 28a-f shor Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director New Delhi, India 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with B24 Nizamuddin East, FF 110013 Germany 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 **K** No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural" 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Administration Development. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Otto Eduard August Birckenstaedt Erica Magdalena Gertrud Simons and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Ravi Hans Vir Bhatia - Son 10 Limes Gardens, London, UK SW18 5HP 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 04/06/2012 Falls Church, VA Signature of Funeral Service Licensee 22. Name and Address of Facility National Funeral Home Kart Blake M01477 7482 Lee Highway Falls Church, VA 22042 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 4 1/2 Years Immediate Cause (Final Ph sician/ Malignant Peritoneal Mesothelioma Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month 5 Other (specify) Day Year Pregnant at time of death signed by the a 1 ☐ Yes ∠ 2 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 \square Yes 2 X No 3 \square Probably 4 \square Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law has perform this certificate 1 Yes 2 No Yes 2 K No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗓 No Other: ည 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director; After 1 X Natural 5 Pending death. 1 Tes 2 No within 24 hours after death
To the Funeral Director; A
completed filled in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/4/2012 homas D50534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Masterson MD 6858 Old Dominion Dr. #104 McLean, VA 22101

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month)

APR

0 6 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Alice M. Bittner Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Western MD Regional Medical Center Cumberland, MD Allegany Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours 215-18-8072 90 **Director** 1 M 2 XF Oct. 26, 1921 Usual Residence of Deced Frostburg MD 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Garrett Frostburg 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 127 Bittner Rd 21532 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 'natural", 3X Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) l Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Medical Nurse and Mental Hygie is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Cordelia (Robeson) Ravenscroft Merton L. Ravenscroft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. Heidi A. Shadel 300 W. Finzel Rd., Frostburg, MD 21532 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Scarpelli Crematory | Mar 30, 2012 Cresaptown, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hafer Funeral Service, PA John J 1302 National Hwy., LaVale, MD 23a. Per 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death .Ph_sician/ neumonia disease or condition Medical resulting in death) e to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to for as a consignation of cause. Enter Underlying burial-transi The law requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Year be detached g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ fibrillation 1 🗆 Yes Completed 2 No 3 ☐ Probably 4 ☐ Unknown should diastolic heart failure Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical Hospital or Attending Physician: filled in by the funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes 1 KInpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation
6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only q Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa

State Registrar W. Nowbrook R

pleted cause of death (Item 23a) (Type, Print)

12501

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ [™]Atpr 6, 2012 Broadwater 1625 Laura Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frostburg Village Nursing Home Frostburg Allegany Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 X 219-44-2433 89 Aug 79°11922 **Director** Usual Residence of Decedent 28a-f show 10a. State must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Allegany MD Cresaptown 1 XYes 2 No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must be Completed by Funeral 12802 Darrows Lane 21502 USA 12. Was Decedent Ever in U.S. Armed Forces 1 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Martha Catherine Platter James Albert Broadwater 19a. Informant's Name/Relationship (Type, Print) Elaine Brumfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 218 Lacey Lane Maysville WV 26833 daughter injury or other 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite any injury or ot Date Restlawn Wemorial Gardens 4/10/201 LaVale MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name ar Scarpellif Furilleral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final son vascely accident Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Year Dav 1 | Yes 2 L Unknown s been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Shknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 this certificate 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 1 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 vursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide Pending Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Tip Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Broadway

Registrar DHMH 17 Rev 7/2009 MD

J.M

APR 1 9 2012

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Randall Brian Bair Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Allegany Western Maryland Health System Cumberland 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 219-58-5024
Usual Residence of Decedent **Director** 1**X** M 2 □ F 57 09/09/1954 MD 28a-f show at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD Carroll Westminster 1 🗌 Yes 2 🛣 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a 332 Mary Avenue 21157 USA items 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No 19 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Examiner 9 þ 1978-1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", 3 Widowed 4 Divorced 1985 Specify: White Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than College (1-4 or 5+) filed within al Hygiene. Elementary/Secondary (0-12) handicapped n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H Elizabeth Wilt Roger Bair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1 and 2 s of Health item 27 Elizabeth Bair/mother 200 Wyndtryst Drive, Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other placel 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Gard. 04/13/2012 Finksburg, MD 22 NPritts Femeral Home and Chapel, P.A. Funeral Service Licenses - 10 412 Washington Road, Westminster, MD 23a. Part 1, Enterne disease, or complications to et caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Onknown Completed Were autopsy findings available prior to completion of cause of has autopsy death? performed' 2 🗌 No Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: 1. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred after death. Director: After 1 Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical Certifying Physician: The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basing of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) m0036766 mpleted cause of death (Item 23a) (Type, Print) 924 Seton Drive Cumberland, MARYland 21502 Poonai MO VIKramaditya

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2040M DRIL Medical **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MEMORIAL AL BO . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. **Director** 1 M 2 D F -19 28a-f show ms 23a or 28a-f shor must be notified at Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛂 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No and Mental Hygiene.
is marked other than "natural", If Yes, Give Year or Dates Specify: WHITE 3 ₩Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Secondary (0-12) College (1-4 or 5+) CONSTRUCTION SUPERINT Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Due to (or a consequence of) disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate
Cause (Disease or injury
that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ģ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has 1; page 2 s autopsy performed? death? certificate 1 Yes 2 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မှ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work Accident
Suicide within 24 hours after death

To the Funeral Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗀 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 1009311 completed cause of death (Item 23a) (Type, Print) 219 Washinaton State APR 09 Registrar

Bar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3 201^{ea} Clayvolyn Austin Crippen 29 0922 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 545 Bay Street, Apt 9 Berlin Worcester If Under 24 Hrs. If Under 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Min. **Director** 219-56-9189 1 🛛 M 2 🗆 F 55 Usual Residence of Decedent 11-1-1956 MD show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 545 Bay Street, Apt 21811 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 X Never Married 2 Married Yes 2 XNo Maryland 21215-0036 Black If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Self-employed Landscaping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic o traumatic Frank Purnell Virginia M. Crippen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Crippen/Sister 545 Bay Street, Apt 9, Berlin, MD 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plate) Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Cremation, 4-13-2012 4 ☐ Donation 5 ☐ Other (Specify) Direct Dover, DE 21. Signature of Funeral Service Licensee Bennie Smith 917 W. Isabella St. M Funeral Home Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year signed by the at Id be detached for Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page 2 After this certificate 2 2 No 1 Yes funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 8610m Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury work? 1 🔲 Yes 2 No Accident Investigation Could not be hours after deat neral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) To the Hospital within 24 hours a Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 3 🗖 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar DAVID COLLA LL, 31. Date filed (Month, Day, Year)

APR

04

SALISBURY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ZYCA COCKEY AM march Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbur LUICON Regional Medical **Funeral** If Under Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Director 1 🗆 M 2 🔭 MD 28a-f show 10a. State 10b. County be notified at 10c. City, Town or Location Director 10d. Inside City Limits MID 1 Yes 2 No NICOMICO NANTICOKE within 72 hours after death with the ò 10f, Zip Code 10g. Citizen of What Country? 23a Funeral **Examiner must** 20541 NANTICOKE items 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces þ Black, White, etc. "natural", or 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Specify: 3 XWidowed 4 ☐ Divorced If Yes, Give Specify: Completed Year or Dates WHITE Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea any injury or other traumatic event, the Mea once. Elementary/Secondary (0-12) College (1-4 or 5+) ACHINIST MANUFACTURING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ SAMIES HACKETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18266 CANTABETTY DR SALVSBURY, MD 21801
Date | 20c. Location - City or Town, State Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, SBURYLBEMATORY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Ficility

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition resulting in death) GARDIOMYOPATH Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner day, leading to mimediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or) that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires LVIC MASS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown ACUTE - 9N - CHRONIC RENAL FA CUDZ 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an after death.

Director: After this certificate has VALVE DISEASE performe A02410 AVR 2 No 1 🗌 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA |은 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury 5 Pending Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours a Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b, Signature and title of cortifier M.D.

State

Registrar

TOMAS

31. Date filed (Month, Day, Year)

MAR

400 E. Shore

514156414

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SNIETKOSZ

M.0

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Physician/ Month Purnell Frank Cropper 29 12 1310 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death 501156414 REGIONAL MEDICAL HICOMICA TENINSULA 8. Date of Birth (Month, Day, Year) . Social Security Number 6. Sex 1 Year If Under 24 Hrs **Funeral** . Age (In yrs. last birthday) 9. Birthplace (State or Foreign 231-36-9867 Hours Director 1 **X** M 2 □ F 79 Yrs. 05/09/1932 Pennsylvania Usual Residence of Dec 28a-f show 10a. State 10b. County death with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Wicomico Salisbury 1X Yes 2 No or. 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? pe 23a Funeral 21804 USA 229 Hazel Ave. **Examiner must** items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Arm Black, White etc. ō 2 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify ıт Yes, Give Year or Dates.**Army** White "natural" 3X Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meagnes, once, Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Janitorial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Cropper Margie Collom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Clark/Daughter 230 Lakewood Park Dr., Newport News, VA 23602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 3/30/2012 Salisbury Crematory Salisbury, MD 4 Donation 5 Other (Specify) Signature of Funer I Sprvice Licensee 22 Nam and Address of Facility Home Professional Association E 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ASCU D Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 2 No be detached the 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy perform After this certificate 1 Yes 2 No Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita 1 Yes 2 □ No Other: 1 Inpatient 2 KER/Outpatient 3 IDOA 은 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? iniury neral Director: A' filled in by the fu 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Media Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certify Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Sian 29d. Date signed (Month. Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

MAR

30

At

pleted cause of death (Item 23a) (Type, Print)

Dm

32. Registral's Signature

3/29/12

bury MD 2180

100 E. Carroll St.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month 04 Year 12 Annie L. Crews 3:00 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Days South Carolina **Director** 228 52 7874 08/18/1942 69 show at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified MD Clarksburg 1 Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23021 Birch Mead Rd 20871 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Dever Married 2 Married 2 No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 permit, Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ₩ Widowed 4 □ Divorced Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Pre School 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Silas Holmes Mattie Callaham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Hickson daughter 14489 Whisperwood Ct Dumfries, VA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethel Cemetery 04/09/12 Alexandria, VA 22. Name and Address of Facility Greene Funeral Home, 21. Signature of Funeral Service License, 3 Muy 814 Franklin St Alexandria, VA 22314 23a. Part 1. Enter the disease, or conshock, or heart failure. List on plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Breast Cancer, metastatic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has b. performed? Yes 2 No 2 No 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ė Hospital 2 😧 No Other: 1 Tyes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number April 2, 2012 D69916 serson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Nioke Wright

Date filed (Month, D)

MD

Silver Spring, MD

20910

1500 Forest Glen Rd

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Funeral Director		5. Social Security No. 218–16–6]	L27	6. Sex 1 \(\text{M} \) 1 2 \(\text{X} \)		e (In yrs. I 88	as <i>t birthd</i> ay Yrs.	Month	der 1 Year is Days	If Under Hours	24 Hrs. Min.	8. Date of Bir		3	Birthp Coun Mar	olace (Sta try) ylan	ate o <i>r Foreign</i> d	
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Health Health Item 2		Carolyn Smith/Daughter 918 W. Schumanker Manor Dr., Salisbury 20a. Method of Disposition 20b. Place of Disposition (Name of Date Date Date Date Date Date Date Date																
Page 1 tment of tant: If i jury or o		1 🔀 Burial 2 [4 🗌 Donation		3 ☐ Removal fi pecify)	rom State	¢		rematory o	r other plac	e)		2012		lisbu				
permit Depar Impor any in		21. Signature of Fur	neral Service L	licensee Dompx	n -	CFS	P	行 501	and Address Snow	ruher Hill	ăl H Rd.,	ome Pro Salisk	ofes: oury	sional , MD 2	. As 2180	soci 4	ation	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	4 🔲 F	ive Birth	of pregna 2 Feta t time of c	death 3	Ectopi Other	c pregnanc (specify)	ey .				23d. Date of Month		ery Day	Year	
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To the within To the comp			the of certifier	, ruise Flaction	er: 10 tile	Dest of my	Knowledge		9c. License		ана ріасі		29d. Da	ate signed (A	1onth, E	Day, Year)		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 11:15 A M 2012 Lee Medical Darby 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 34510 Wango Road Parsonsburg Wicomico Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 4-27-1945 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 XM 2 □ F Maryland Yrs. Director 219-44-1433 66 Usual Residence of Decedent then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 34510 Wango Road 21849 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 X Married 1963 Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Printer Press Operator Moore's Printing other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Clyde С. Darby Sarah Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Pat Darby - Wife 34510 Wango Road, Parsonsburg, Maryland 21849 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🕅 Burial 2 □ Cremation 3 □ Removal from State New Hope Cemetery 4-7-2012 Willards, Maryland 4 ☐ Donation 5 ☐ Other (Specify) gnatu 22. Name and Address of Facility f Funeral Service Licensee Bounds Funeral Home TO/A 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau is hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying cause (Disease or impury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Tes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Atter this certificate 2 No 1 Tyes Yes within 24 hours after death.

To the Funeral Director: Atter this certific completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpa 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Matural Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a Medical Coftifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗹 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 owce 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Phyllis Clara East 8:12 P M 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 104 Franklin Ave. Worcester Berlin 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗖 F Months Days Hours Min. 8/1 16/1939 **Director** 122-30-3877 72 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director MDBerlin 1 Yes 2 XNo Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 104 Franklin Ave. 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Secretary Community Management should be filed with and Mental Hygien is marked other th Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic a Felix Tavernier Clara Santimore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James W. East / husband Franklin Ave., Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) First State Crem. 4/5/2012 Millsboro, DE 21. Signature of Fune 22. Name and Address of Facility Burbage Funeral Home Service Licens 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Year ned by the a e detached f g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760 P.O. Records, Division of Vital Hospital or Attending Physician: nours after death.

neral Director: After the filled in by the funera 24 hours a Funeral I completed To the I within 2 To the I

Baltimore, Maryland 21215-0036

State

Medical

29a. Certifier

29b. Signatur

30. Name ar

determined

5

title of certifier

10344

ompleted cause of death (Item 23a) (Type, Print)

egistrar's Signatu

onran

🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Alfarad Aquil Evans	Sta 1- For State Registrar	ate of Maryland	/ Department of Certificate of		d Mental Hy		eg. No. 20	12 1228
Physician/	Decedent's Name (First, Middle					Date of Deat Month	th Day Year	3. Time of Death
Medical Examiner						March 26,	2012	0617 hrs
	4a. Facility Name (if not institution Meritus Medical Cente	1		Hagerstowi	Location of Death		4c. County of De Washington	1
Funeral	5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year Months Day		_	th (MM/DD/YYYY) 9. For	reian
Director	154-70-1697	1 XM 2 F 3	5 Yr		75 Hours IIIII.	12-1	8-1976	CountryNJ
any	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Loca	ation		-		10d. Inside City Limits
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Maryland 28a-f show d. at once. ector	MD Washi 10e. Street and Number	.ngton	Hagersto	VII 10f. Zip Code		10	0g. Citizen of What C	ountry?
the Maryland a or 28a-f sh diffied at one Director	102 Linwood	Road		21740			USA	
er death with the Maryland or items 23a or 28a-f abo r must be notified at once. Funeral Director	11. Marital Status	12. Was Deceden		as Decedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-		nerican Indian, Black,
or ite	1 Never Married 2 Married	1 Yes 2	K No			rtiouri, oto.)	Specif Bla	
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5-0036 led within 72 hours afti- tygiene. other than "natural" the Medical Examine Completed by	12		None				None	
5-0 Hygie W	17. Father's Name (First, Middle,				18.Mother's Name			
21215-0036 uld be filed within 7 Mental Hygiene, marked other than c event, the Medica	Henry Brook: 19a. Informant's Name/Relationsh	Soin (Type Print)	19h Mailir	na Address /Stra	Teresa		nber, City or Town, St	rate 7in Code)
O & B	Sunjai Will:							
e, MI 1 and 2 s Health a item 27	20a. Method of Disposition		20b. Place of Dispo	sition (Name of ce		Date	20c. Location - City	
MOF Pages ent of nt: If	1 X Burial 2 Cremation 4 Donation 5 Other Sp		Ever Gr		4-2	-2012	Hillsid	e, NJ
Baltimore, MD permit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	21. Signature of Funeral Service						sabella	
	- Junel	1001	F	uneral	Home Sa	lisbur	y, MD 21	801
Physician /Medical	23a. Part I. Enter the disease, or failure. List only one cause	on each line.		the mode of dying	, such as cardiac o	r respiratory arre	est, snock, or neart	Approximate Interval Between Onset and Death
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ox 68760 eath certificate to attending physic for use as the bu	1F FEMALE: 23b. Was decedent pregnant in th		ome of pregnancy	etal death 3	Ectopic pregna	ancy	23d. Date of delive	very Day Year
Box 6876(death certificate the attending phy dor use as the t nysician/M	past 12 months?		t time of death	Other (Specify)				9
box 6876 the death certificate the attending phy the attending phy ched for use as the! Physician/M	Part II. Other significant conditi	nown 9 Unknown	Ale but not any liting in the	underhing og up	aives is Dart I	23a Did to	phacco use contribute	to the cause of death?
i, P.O. E	Part II. Other significant conditi	ons contributing to dea	th but not resulting in the	underlying cause	given in Pait i.			Probably 4 Unknown
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COT law re thas b e 2 sho			-			autop perfor	rmed? death	
Vital Rec ysician: The I his certificate I director, page	25. Was case referred to medical			26 Place	e of Death (Check	1 Yes	2 No 1	Yes 2 No
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Division of Vital Records, P.O. spital or Attending Physician: The law requires that the tours after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach Certification: To Be Completed by P	3 Suicide 6 Coul	d not be 28e. Place of I	njury - At home, farm, stre ngle Family Home	eet, factory, office	building, etc.	or Town, S		Rural Route Number, City n, MD
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b Medical Certification: To Be Completed by Physician/Me	se(s) and manner as s and place, and due to							
E 8 4 8 4 8	29b. Signature and title of certifie	and manner stated		29c. Licens	se number		29d. Date signed (Month, Day, Year)
	Carol	Halla	n	O.C.	.M.E.		March 27, 201	2
210	30. Name and address of person			Jalana a Col di	D-W	D 24222		
9	24 Data filed (Month Day Vacal	20 Ponietr	miner 900 W. Ba	intimore Street	, Baitimore, M	D 2 1223		
State Registrar		912 Jenus	D. par					
DHMH 17 Rev 1/2001		0011	ORIGINA	AL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mar 30 , 2012 Physician/ 11:40 AM Failinger Margaret Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Co. Heath INurs. & Rehab Ctr. Cumberland Allegany 9. Birthplace (State or Foreign Country) OH If Under 1 Year If Under 24 Hrs Date of Birth 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 DX Dec 18 Months Days Hours Director <u>220-32-2645</u> 76 or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a, State within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Cumberland MD Allegany 1 Yes 2 XNo 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral USA 21502 14318 Winchester Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates 3 Widowed 4 X Divorced white other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Explosives Expert Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gertrude R. Robinson unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 14318 Winchester Road Cumberland MD 21502 Jennifer Hutzell daughte 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Restlawn Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State 4/5/2012 MD LaVale 4 Donation 5 Other (Specify) of Funeral Service L Si ature 22. Name and Address of Eacility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) STAGE Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-trans that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the burial. Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has Yes 2 No 1 Yes 2 No certificate within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗌 Yes 2 🗹 No Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 🗀 ER/Outpatient 3 🔲 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred injury 1 Natural 5 \square Pending 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 — Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number en 30. Name and address of person who completed cause of death (ten) 23a) (Type, Print) 200 Glenn St. Ste. 302 Cumberland, MD 2150 W.D stiano 32. Registr State 9

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edwin Barringer Goodridge 201 \mathbf{P}^{M} :04 Apri Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Berlin Nursing and Rehab Center Worcester If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday, 9. Birthplace (State or Foreign **Funeral** NY Nac Days 1 **K** M 2 □ F Months Hours Min 1473/1919 92 **Director** 118 05 1205 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes Ž ☐ No MD Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 9715 Healthway Dr. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2X No Specify: Specify: white Completed 3 Midowed 4 Divorced Year or Dates. Army the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) General Manager Insurance Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Monroe Goodridge Leona V. Breese Goodridge, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet T. Owens (daughter) Berlin, Broad St. MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Millsboro, DE 4/4/2012 StateCrematory 21. Signaturo f Funeral Service 22. Name and Address of Facility The Burbage Funeral Home 108 Willaim St. Berlin, MD 21811 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a. End Stage Dementia
Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner Coronary Artery Disease Sequentially list conditions, Examine cause. Enter Underlying Hypertension or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Dav 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 YUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 No 1 Yes 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) B 12 Other: 1 Tes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 2 Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 XCertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier R 131285 April 3, 2012

€) |2+) State

Mary Bernal-Clark,
31. Date filed (Month, Day, Year)

APR 0 5 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FNP-BC, 9715 Healthway Dr, Berlin, MD

Registrar's Signature

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Midgle, Last) 2. Date of Death 3. Time of Death Graybeal, Melvin Physician/ Month Milvin 11:07 1 MM MATE Medical 4a. Facility Name (if not institution, give street and number, or Location of Death Examiner 4b. City. Town 4c. County of Death River HUNEY SULKLE delle Balhmore 8. Date of Birth (Month, Day Year) Sex 1 M 2 F 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Min Country) Maryland 219-42-5440 Director 64 Usual Residence of Decedent ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Middle River Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 35 Honeysuckle Lane 21220 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 X Never Married 2 Married 21215-0036 If Yes, Give Year or Dates. Vietnam 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry V.A. Maryland Healthcare System (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Twelve Years Building Management Perry Point, Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of David Graybeal Carrie Lee Madron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If Item 27 is any injury or are Ralph Graybeal (Brother) 1614 Liberty Grove Road, Conowingo, MD 21918 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State West Chester, R.A.Ferris & Co., Inc. 04/04/12 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset a. d Death Immediate Cause (Final Physician/ Hypertensing disease or condition resulting in death) Medical or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did topacco use contribute to the cause of death? Completed by DIAM Mellity. 1 V Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed has e 2 this certificate har ral director, page 2 No 11 MILLEMIN 1 Yes 25. Was case re rred to medical examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital: Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Nesidence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Mayer of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Cortifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledgs, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tit Mrc(30. Name and address of p n who completed cause of death (Item 23a) (Type, Print) 5+IVA Wit EU6ENE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			AMEND 24A-297	ise Type or A, PER MD State c	Print G932 f Man					ure A	II Copie iental Hy	s Ar /gien	e Leg	ible.	12	288
		_	1 State Registrar 1. Decedent's Name (First, Middle	e Last)		C	ertificat	te of E	Death		2. Date of De	Reg. N	lo. 2 L) 2		
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- el	Examir	er	4a. Facility Name (if not institution 6526 Greenmour	nt Drive					Location o			4	c. County H	of Death OWard		
	Funeral Director		5. Social Security Number 215–20–4221 Usual Residence of Decedent	6. Sex 1 □ M 2 X F	7. Age (In	yrs. last birthday Yrs.	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bi				ace (State or 1 y) yland	Foreign
	and show dat	tor	10a. State 10b. County		10c. City, Town or Location								10	d. Inside City	Limits	
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920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Mari 3 X Widowed 4 Divorced	If You City	rces? 2 X No e	in U.S. 13	. Was Dece If Yes, spe 1 Yes				cify Yes or No Rican, etc.)	-		e - America k, White, e	c.	
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	id 2 should I salth and Me n 27 is marl er traumati		19a. Informant's Name/Relationsh Violet Cousin/I				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S 7347 Kerry Hill Court, Columbia, MD									
Baltimore,	. Page 1 and tment of Heal tant: If item 3 jury or other		20a. Method of Disposition 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from Specify)	State	20b. Place of Dis cemetery, cr St. James Church	oosition (Na ematory or Free Cemet	me of other place Met ery	hodis	_	ate 28/201:	İ	Location -	•		D
Ball	permit Depart Impor any in once.		21. Signature of Funeral Service L	en ee	-(F)	P	Name ar Stewar 321 We	d Addres Fu	s of Facility neral	y Hom	e by Ho bury, I	ollo	way a 21801	and D	owney,	P.A.
اسعر المحمديد	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	_a de	me	e death. Do not en	nter the mod	de of dying	, such as	cardiac o	respiratory a	rrest,			Approximate Interval Betwe Onset and De	een
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. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be exwirin! 24 hours after death. To the Euneral Director. After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	I Live Birth 2 Li Fetal death 3 Li Ectopic pregnancy							23d. Date Mon	e of deliver	y Day Yea	ar		
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<u> </u>	Physion this of all directions	욘	1 Yes 2 X No 27. Manner of Death	Hospital: 1 🔲 I 28a. Date o		2 ER/Outpati			4 ∐ Nı		ne XX Resi					
Division of Vital Records,	tending I leath. :or: After the funer	Certificate:	1 X Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	g (Monti gation	h, Day, Ye	ar) 280. Time injury	M	28c. Injury work? 1 🗆 \	res 2 🗌		8d. Describe I	now inju	ry occurred	d		
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	To the Hospital or varithin 24 hours after To the Funeral Direction completed filled in b	Medical	only one) 3 Certifying	Physician: To the be xaminer: On the basi Nurse Practioner: T	s of exami	ination and/or inve	stigation, in	mv opinior	n. death oc	curred at t	he time, date a	and place	e, and due:	to the caus	e(s) and mann	er stated.
	To wit		29b. Signature and title of certifier	nPas	B	CRUP	290	E. License	number ムヨウ	794	Z	29d. Da	ate signed	(Month, Da	20/2	۷.
	UTE		30. Name and address of person v	who completed cause	of death	(Item 23a) (Type,	Print)	Dr.	# (Ĝ.	Lint	hic	um	ME	210	90
	Stat Registra	G	31. Date filed (Month, Day, Year)		gistrar's S		CAL									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 23a.Pt.II.25.per me, g926 4-30-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9:38 A RANDOLPH EDWARD HUGHES April 2012 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Dorchester 6724 Bobtown Road Hurlock If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. **™** M 2□ F 66 216-44-7874 Maryland May 15, 1945 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Event are considered. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Hurlock 1 ☐ Yes 2 X No Dorchester Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21643 6724 Bobtown Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes ≥ ₩ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 □Yes 2√□No Specify: Black 3 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Poultry Live Catcher 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Mae Robinson John A. Hughes ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4707 Hughes Court, Hurlock, MD 21643 Joanne Hughes/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/10/12 Cambridge, Maryland J.R. Briscoe Mem. Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Framptom Funeral Home, P.A. skin 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 4 hours /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last THE CATION APPROVED TO MEDICAL EXAMINER Examine or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectonic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ş 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe Yes 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 □ Nursing Home 5 D Residence 6 □ Other (Specify)
Injury at 28d. Describe how injury occurred Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1**⋉** Yes Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Deat 28c. Injury at Work? 28b. Time of 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifie cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

2 Blins AVE HURLOCK MD 21643

completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Year 31 4:45 Raymond Alexander Hill March Α Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 8 Date of Righ 7. Age (In vrs. last birthday, **Funeral** (Month, Day, Year) Hours **Director** 256-28-8096 1 XM 2 □ F 89 7/11/1922 Georgia Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1XX Yes 2 No DC Washington r must be r 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1505 Roxanna Rd. NW 20012 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Examiner Armed Forces?

1 Xyes 2 No
If Yes, Give
Year or Dates. WWII Black, White, etc. ō à 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify Specify: Black "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. other than " rent, the Med life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Electrical Engineer Government of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Raymond Hill Mary Grant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Hill/Wife 1505 Roxanna Rd. NW Washington, DC 20012 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State . of P cemetery, crematory or other place, 1 Durial 2 X Cremation 3 Removal from State Department of Important: If any injury or Fort Lincoln Crematory 4/5/2012 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice 22. Name and Address of Facility Fort Lincoln Funeral Home Bladensburg Rd. Brentwood, MD 20722 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed and the burial-trai that initiated events Due to (or as a consequence of resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death been signed by the a should be detached f 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perforr death? 2 🗆 No 1 Yes Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner.

1 Yes 2000 nours after death. neral Director: After this or y filled in by the funeral dire Other: မ 1 → patient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours a

To the Funeral C

completely filled Medical 10 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier

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30. Name and address of person who com

Augali Singh, MD Deted cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #8 per Ifor. 4/6 Geztificete of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Brian Ward Hudson March 31, 8:45 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Tate Chesapeake Hospice House Anne Arundel Linthicum 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 219-40-6432 1 🔀 M 2 🗆 F Director 67 April 26,1944 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director MD Prince Georges Fort Washington 1 XYes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7619 Blanford Drive 20744 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force 1 X Yes 2 If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give 1965–1985 Year or Dates. within 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life...DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Secondary (0-12) Enlisted Military injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Hudson Alta Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sint of Health at 1f item 27 i 13111 Hearthside Lane, Fairfax, VA 22033 Lee Hudson/Son Department of He Important: If it any inition 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Georgetown University Medical Center 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 2012 4X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. 21. Signature of Funeral Service License /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final .Physician/ ROGRESSIVE METASTATIC disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of,: Exami or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of). resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending plant for use as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death the g Unknown 9 Unknown signed by tall do be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen . Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performed death? certificate ! 2 No 1 Yes Yes 2 N 26. Place of Death (Check only one) 1050ico 25. Was case referred to medical Be Hospital Other: 2 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this eral Director: After thi filled in by the funeral 27. Mann f Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Acciden
☐ Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D

completely filled To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

2000

Be prophocographes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene 2012 12292

			State Registrar		Cer	tificate of L	Reg. No.					
Physician/ Medical Examiner			1. Decedent's Name (First, Middle, Last)	HARR	Ī5			2. Date of Dea	Day Day	Year 3. Time of Death		
			4a. Facility Name (if not institution, give str Mandrin House			4b. City, Town, or Harwoo	bd		4c. County of Death Anne Arundel			
all	Funeral Director		5. Social Security Number 6. Sex 578 - 26 - 9693 1	7. Age (In yrs. la M 2 11 85	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day		9. Birthplace (State or Foreign Country) Michigan		
	Maryland 28a-f show ptified at	Director	MD 10a. State 10b. County Prince Ge		, Town or Locadover	cation				10d. Inside City Limits 1 ☐ Yes 2 No		
	with the is 23a or 2	Funeral Di	10e. Street and Number 8605 Dunbar Ave			10f. Zip Code 20785			10g. Citizen of \	What Country?		
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☒Widowed 4 ☐ Divorced	Was Decedent Ever in U.S Armed Forces? □ Yes 2 X No If Yes, Give Year or Dates.	1	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 🔀 No	n, Mexican, Puerl	pecify Yes or No- o Rican, etc.)		ee-American Indian, ck, White, etc. :: White		
1215-	thin 72 ho ene. than "nai he Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give I	dent's Usual Occupa kind of work done o O NOT use retired) naker	ation furing most of wo	rking	16b. Kind of Bi	usiness/Industry		
Maryland 21215-0036	I be filed wi lental Hygis rked other lic event, t	To Be (17. Father's Name (First, Middle, Last) Edmond Groleau		Homen	aarcı .		me (First, Middle, Groleau	Maiden Surname			
, Mary	nd 2 should saith and M n 27 is ma er traumai		19a. Informant's Name/Relationship (Type Karen Harris/Daugh		19b. Mailin	ng Address (Street & 2 Davids C	and Number or Ru onville l	ral Route Number Rd/Davids	; City or Town, S SONVILLE	State, Zip Code) e MD 21035		
altimore,	. Page 1 ar ment of He tant: If iter jury or oth		20a. Method of Disposition 1 ☐ Burial ※ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	amount from Ctata	emeterv. cren	sition (Name of natory or other plac Ltan Crem	atory 4/	Date 1/12		- City or Town, State dria VA		
Balt	permit Depart Import any inj		21. Signature of Funeval Service Licensee	MD 997	Ac F	dvent fun a11s Chur	eral and	l Cremati nd Annapo	lon Serv ol i s MD	ices		
) () () () () () () () () () (Physician/ Medical Examiner	ıer	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	that caused the death of up on each line. Due to (or as a consequence)	OBS		^			Approximate Interval Between Onset and Death		
0	rificate be executed ing physician and e as the burial-transit	Medical Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last d.	Due to (or as a conseque	ence of):							
. Box 68760	death cel	_	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome of pregnar 1 Live Birth 2 Fetal 4 Pregnant at time of do 9 Unknown	death 3	Ectopic pregnanc Other (specify)	у			ite of delivery onth Day Year		
ds, P.O.	requires that the bear signed by should be deta	Completed by Physician	Part II. Other significant conditions cont	ributing to death but not resu	ulting in the u	nderlying cause giv	ren in Part I,			ribute to the cause of death? 3 □ Probably 4 Ū Unknown		
Reco	rsician; The law rescribility cartificate has buildirector, page 2 sh							24a. Was a autop perfo 1 \(\sum \) Yes	med?	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
Division of Vital Records,	ding Phy h. After this funeral (To B	27. Manner eath 1 atural 5 Pending 2 Accident Investigation	spital: 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year)	ER/Outpatien 28b. Time of injury	other 3 DOA Other 28c. Injury work	4 ∐ Nursing F	tome 5 🗆 Resid	ence 6 Tothe ow injury occurre			
Divisi	ital or Attendurs after deat ral Director:		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)		eet, factory, office		28f. Location (S City or Tow		er or Rural Route Number,		
	To the Hospita within 24 hours To the Funeral Completely fille	Medical	(Check 2 Medical Examine only one) 3 Certifying Nurse	an: To the best of my knowle r: On the basis of examination Practitioner: To the best of m	and/or invest	igation, in my opinio death occurred at the	n, death occurred he time, date and p	at the time, date a place, and due to the	nd place, and due ne cause(s) and n	e to the cause(s) and manner stated. nanner as stated.		
	5		29b. Signature and title of certifier		SIP	29c. License	187C	3	29d. Date signed	d (Month, Day, Year)		
	14		30. Name and address of person who don JONEVIEVE LITH 31. Date filed (Month, Day, Year)	10R,445D	EFEV		NF, Pa	NAPOLI	S, M.	1).21401		
	Stat		ADD 0 A 2012	32. Registrar's Signatu	re							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death. 3:45 Physician/ Month 2 0 1Z ord Richard Lee Hartle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington <u>Mertius Medical Center</u> Hagerstown 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Days 204-01-8525 **Director** 1 **X** M 2 □ F August 7, 1921 Maryland 90 Usual Residence of Deced or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No Hagerstown Maryland Washington 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or must be r Funeral within 72 hours after death with 21742 USA 14727 Pennsylvania Avenue ral", or iten Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 X Yes 2 □ No
If Yes, Give Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", 3 Widowed 4 Divorced Specify: Year or Dates.1942-1946 White 1 and 2 should be filed within 72 hours of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Senior Test Engineer Crane Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Stanley Wade Hartle Eleanor Elizabeth Barnhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14727 Pennsylvania Avenue, Hagerstown, Maryland 21742 Myrtle L. Hartle, wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State . Page 1 ō <u>=</u> 0 1 🕅 Burial 2 🗌 Cremation 3 🗌 Removal from State permit. Page Department of Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Beautiful View Cemetery 4/11/2012 Middleburg, Maryland 22. Name and Address of FacilityAndrew K. Coffman Funeral Home, 21. Signature of Fu 40 East Antietam Street, Hagerstown, MD 23a. Part 1. Enter the disease, or complications that causely the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death teretion Immediate Cause (Final Ph sician/ Cerebras disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): executed Cause (Disease or injury nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the ail g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dement: a 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 2 🗌 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 12 Hospital Other: 1 Impatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural (Month, Day, Year) 5 Pending work 1 Tes 2 No Accident Investigation 6 Could not be 3 ☐ Suiciue 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D060396 04/10/12

State Registrar Hogerstown

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WALZHED

ARID

APR 1 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 1320 Billy Jenkins, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Snow 4b. City, Town, or Location of Death Examiner Hill Worcester Harrison Senior Living Snow Hill 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MD Country) Days Min. Hours 6-14-1931 Director 214-30-8229 80 Usual Residence of Decedent or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 Tes 2 X No Snow Hill MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21863 218 East Martin Street death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married þ 72 hours after Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Spec Black If Yes, Give Year or Dates "natural" 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Mechanic Barr Farms permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygik Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Theodore Jenkins Grace Ayers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin St, Snow Hill, MD 21863 <u>Geraldine Jenkins/Wife</u> <u> 218 East</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Girdletree, MD Coolspring Cem 4-7-2012 Signature o Funeral Service Licensee Isabella St. 917 W. 22. Name and Address of Facility Bennie Smith Salisbury, 23a. Part 1. Exter the disease, or complications by t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Interval Between Immediate Cause (Final Onset and Death Physician/ a disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 2 No sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2. No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate l 1 Yes 2 No Yes 2- No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No မ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State, Medical 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one ture and title of certifier 12012 00054422

Registrar

egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jocelyn Melvina Cook Johnson 03 04 2012 0220 \mathbf{A}^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Hours Director 578-58-8525 1 🗆 M 2 💢 68 8-9-1943 DC show or 28a-f shov notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DC Washington 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ms 23a or must be Funeral 1810 Alabama Ave., SE 20020 er than "natural", or items the Medical Examiner mu 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ntal Hygiene. ed other than event, the M Elementary/Secondary (0-12) College (1-4 or 5+) Providence Hosp. Food Service 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H 27 is marked of er traumatic even ည Allen Norwood Cook Sr. Melvine Martha Harns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Isreal Johnson 200 Elmira St, SW #B2, Wash. D.C. 20032 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 5 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) ÷ 5 Department of Important: If any injury or Suitland, MD Washington Natl. 4-9-2012 4 ☐ Donation 5 ☐ Qther (Specify) 21. Signature of Uneval Service Lin 22. Name and Address of Facility D. L. McLaughlin Funeral 2518 Pennsylvania Ave. SE, Wash. D.C. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Hypovolemic Shock disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Upper gastrointestinal hemorrhage Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami Acquired coaqulopathy or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of). resulting in death) Last the attending physician hed for use as the buria Physician/Medical P.O. Box 68760 as IF FEMALE: signed by the attending d be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Day Pregnant at time of death 1 ☐ Yes ∠ ■ g ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been signe page 2 should be End stage renal disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Cerebrovascular accident 24a. Was an performed? Yes 2 Au after death.

Director: After this certificate of in by the funeral director, pag Atrial fibrillation 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in rily opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D52503 04-03-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Glan Rd, Silver Spring HD 20910 Shein 1500 Forast 31. Date filed (Month, Day, Year)

APR 0 6 2012 State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ Day 0730 M 7 2012 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Director 1 **X** M 2 □ F 400-26-1167 95 Apr. 3, 1916 Louisville, KY 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1X Yes 2 ☐ No MD Baltimore Ellicott City 10e. Street and Numbe 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral United States 3002 N. Ridge Rd #H414 items. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1

X Yes 2 □ No Black, White, etō 1 Never Married 2 Married ò African Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Year or Dates. 1943-46 3 X Widowed 4 Divorced Completed American the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 4 Postal Service Manager U.S.Government Be other traumatic event, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Department of Health and Mont. Important: If item 27 is marked any injury or out. Claude Elliott Johnson <u>Bessie Steele</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Don E. Johnson/son 507 O St. NW #4 Washington, DC 20001 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 4/3/2012 Beltsville, MD 22. Name and Address of Facility McGuire Funeral Service INC. 21. Signature of Funeral Service Lice 7400 Georgia Ave. NW Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Phylician disease or condition resulting in death) Spiraturu Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to lor as a consequence of typotension The law requires that the death certificate be executed and I-tran Due to (or as a consequence of) resulting in death) Last burial physician s the burial Physician/Medical Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Month Year Pregnant at time of death Dav 9 Unknown 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown ransaminiti Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? Yes 2 No 2 🗌 No certificate ementi 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗀 Other: မ 1

✓ Inpatient 2

ER/Outpatient 3

DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred al Director; Afte 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 24 hours after de Funeral Directo letely filled in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hou To the Fune completely fi 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated WA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Davana

31. Date filed (Month, Day, Year)

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2001

32. Registrar's Signrature

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DHMH 17 Rev 06-2011

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		For	State of M	arylan	d / Depa	artment of H	Health and	Mental Hy	giene)		
		State Registrar			Cer	tificate of L	Death		Reg. No	20	12 1229	
Physicia	n/	1. Decedent's Name (First, Middle		_				2. Date of De Month		av • Ye	3. Time of Death	
Medic	al		Dean Harri	s Jac	ckson			April	L 2 ,	201	2 9:00 AM	
Examin	er		ional Hosp			Lai	r Location of Deal		1		e George's	
Funeral Director		5. Social Security Number 259–36–6757	6. Sex 7. Åg	e (In yrs. la 81	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			1930 ^{g.}	Birthplace (State or Foreign Country) Georgia	
nd now at	-	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loc	cation					10d. Inside City Limits	
s after death with the Maryland ral", or items 23a or 28a-f show Examiner must be notified at	Funeral Director	District of Co	lumbia			nington					1 X Yes 2 □ No	
the M	Ē	10e. Street and Number				10f. Zip Code	_		10g. Ci	it Country?		
h with	nera	711 Van Buren	Street, N.	W.		2001				ited S	States	
r deat r iten iner r		11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent I Armed Forces?		S. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)	.		American Indian, Vhite, etc.	
be filed within 72 hours after death with the Maryland ental Hyglene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	ed by	3 X Widowed 4 Divorced	If Ven City	,No	1	☐ Yes 2 🗶 No	Specify:			Specify: B	31ack	
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led wi Hygid other ent, t	Be (17. Father's Name (First, Middle, L	ast)			REDUIC WE		me (First, Middle,	Maiden			
d be fi Aental arked tic ev	၀	Willie Hill	Harris					nie Mae		rter		
permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once.		19a. Informant's Name/Relations	nip (Type, Print) Daug	htei	19b. Mailin	g Address (Street			-			
and 2 Health Her tr		Joan Jackson R	edearn-Thomp	7		Amer Driv	e;Fort V	Vashingt				
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Dep lmp any		Thetat (n 1-1	20333							gton,D.C.20011	
		23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused	the deat	_	r the mode of dyin	g, such as cardia	c or respiratory ar	rrest,		Approximate Interval Between	
Physician/		Immediate Cause (Final disease or condition	_ S'evere	R	ecurr	ent Me	tabolic	Acido	sis		Onset and Death	
Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):					***		
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atten atten for us	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		2 Feta	I death 3	Ectopic pregnanc Other (specify)	СУ			23d. Date of Month	f delivery Day Year	
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ig Phy ter this neral o		27. Manner of Death	28a. Date of inju	ry	28b. Time of injury	28c. Injun	y at	28d. Describe			pecity)	
eath. or: Af the fu	fica	1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	gation	, , , , , , ,	injury		Yes 2 No					
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Certificate;	4 Homicide determ		ry - At ho . <i>(Specify</i>	me, farm, stre	et, factory, office		28f. Location (S City or Tov			r Rural Route Number,	
spital		29a. Certifier 1 Certifying	Physician: To the best of	mv knowl	edge, death o	ccured at the time	, date and place.	and due to the ca	use(s) ar	nd manner as	s stated.	
n 24 h	Medical	(Check 2 Medical E	xaminer: On the basis of e Nurse Practioner: To the	xamination	and/or invest	igation, in my opinio	on, death occurred	at the time, date a	and place	, and due to t	the cause(s) and manner stated	
vithi Von	_	29b. Signature and title of certifier	00			29c. License	e number			te signed (Mo	onth, Day, Year)	
5		I The	Clear			Doc	12962	2	A	pril	2, 2012 Dusen Rd.	
R	2	30. Name and address of person value Lee-	who completed cause of d	eath (Item	23a) (Type, P	rint)	1 Uaca	tal 7.	300	Van	Dusen Rd,	
Stat	e	31. Date filed Many, Ay, Ray	19 \$ 32. Registra	ar's Signat	ure /	i Region	101 11050	NICH L	<u>-aur</u>	-e1, 1	VID 20.10.1	
Registra		APR U UZU	IC Charles	p.	MARK	3						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Claude Lawson Jr. 2220 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Rehabilitation Wicomico Salisbury bur Mursinge If Under If Under 24 Jrs 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 Months Days Hours Min 83 (Month Day Year) 03/23/1929 Virginia **Director** 215-24-1025 Usual Residence of Decedent show 10a. State 10b County 10c. City, Town or Location with the Maryland event, the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 X No Maryland Worcester Berlin 9 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 41 Bramblewood Drive 21811 USA permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Framinar most 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 1 Yes 2 □ No If Yes, Give Marine Year or Dates. Corp Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Completed 3 Widowed 4 X Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College_(1-4 or 5+) Police Officer Law Enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Claude Lawson Sr. Emma Eunice Norman 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Perhall Court, Baltimore, MD 21236 Donna M. Stetka/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4/4/2012 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 21. Signature of Funeral Sevice Licensee ²Horloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Keller 23a. Part 1. Enter the disease, of shock, or heart failure. List occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Interval Between Cardib Vescula Immediate Cause (Final Onset and Death Throsderatic Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to minimulate cause. Enter Underlying Cause (Disease or iinjury that initiated events for use as the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy After this certificate | 2 No 1 Tes Yes 2 No To the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 No. Other: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death. To the Funeral Director. Af 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

TO

State

Registrar

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Nicholas dia Donode 31. Date filed (Month, Day, Year) 4

completed cause of death (Item 23a) (Type, Print)

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29d. Date signed (Month, Day, Year)

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Physicia Medical Exami	-	1. Decedent's Name (First, Middle,Last) Michael Ambrose L	armore					2. Date of De Month March 20		/ Year		3. Time o	
		4a. Facility Name (if not institution, give street and numb Peninsula Regional Medical Center	er)	4	b. City, Tov Salisbu		cation of Deat	h	ľ	4c. County of Wicomico			
Funeral Director		5. Social Security Number 6. Sex 7. 219-82-7753 1X M 2 F	Age (In yrs. last I 48	birthday) Yrs.	If Under Months	1 Year Days	If Under 24Hr Hours Min	_		м/DD/YYYY) .963	Foreign		tate or land
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aryland	Director	Maryland Wicomico 10e. Street and Number		Salis	10f. Zip Co	ode			10g. C	itizen of Wha			25 2 110
the Man or 2		700 Canvasback Court			2	21804	4			USA			
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 33a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Force 1 Yes 3 Widowed 4 Divorced If Yes, Give Yeer		If Ye	s, specify (Cuban, N	fexican, Puerto	pecify Yes or No Rican, etc.)	No-	14. Race - White, Specify:			, Black,
72 hours aft n "natural" al Examine	Completed by	15. Decedent's Education (Specify only highest grade of Elementary/Secondary (0-12) College (1-4 of Elementary/Secondary (0-12)	a. Decedent	Yes 2 X No specify: lent's Usual Occupation (Give kind of work done most of working life. DO NOT use retired)					. Kind of Busi	ness/Ind	dustry		
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	17. Father's Name (First, Middle, Last) Larry Hugh Larmore 19a. Informant's Name/Relationship (Type, Print)		40h Mailian	Address		Betty	e (First, Middle Jean N	Muir		04-4-	7:- O- d-	,
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Ore, Nges I and to of Health		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from	State crem	ce of Disposit natory or other	er place)			Date	1	c. Location - C			te
Baltimore, permit. Pages I a Department of He Important: If its injury or other ti		4 Donation 5 Other Specify: 21/ Signature of Funeral Service Licensee	Sali	sbury	Crema	tor	y 3/	30/2012	2 5	Salisbu	ry,	MD	
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Physician /Medical !xaminer	Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of t	nsequence of):	of Chest									n Onset and Death
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1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Certification:	4 Homicide determined (Specify) S	Injury - At home ingle Family		, factory, of	tice build	ding, etc.	28f. Location or Town, 700 Canvast	State)				lumber, City
To the How within 24 h To the Fur	edical	29a. Certifier 1	kamination and/o									ause(s)	
To with To com	Med	29b. Signature and title of certifier	00.			icense n				Date signed		, Day, Ye	ar)
FTC		30. Name and address of person who completed cause of Patricia Aronica-Pollak MD. Assistant	f death (Item 23a Medical Exa	*	000 W. B	altimo	re Street, E	Baltimore, N	/ID 21	223			
	ate rar	31. Date filed (Month, Day, Year) 2012 Regist	rar's Signature	Book	1	-							

DHMH 17 Rev 1/2001 OCME 2006 ----

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month April 2012 9:18 P M Hannah Elizabeth Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Caroline Nursing Home Caroline Denton 9. Birthplace (State or Foreign Country), Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, March 27 7. Age (In yrs. last birthday) **Funeral** Social Security Number Hours 1 □ M 2 🗓 F ປີ 920 92 213-18-5696 Director Usual Residence of Decedent show if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Caroline Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 209 Sunrise Ave. 21660 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Saltimore, Maryland 21215-0036 1 Yes 2 X No White 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) graduate seamstress shirt factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edgar Thomas Faulkner Ella Mae Starkey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Murphy, 3281 Ingram Branch Road; Harrington, DE 19952 son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Greensboro Cemetery Apr 5 2012 Greensboro, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensed 22. Name and Address of Facility PO Bx 160; Greensboro, MD 21639 Fleegle and Helfenbein Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Physician/ IN disease or condition resulting in death) Medical Due ! Examiner Sequentially list conditions. cause. Enter Underlying Cause (Disease or linjury Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 □ Probably 4 □ Unknown Division of Vital Records. 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has page 2 performed 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death funeral 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation Accident the f Suicide Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b, Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, 31. Date filed (Month, Day, State

DHMH 17 Rev 7/2009

Registrar

APR 95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Mitchell March 27, 4:20 PM Dorothy Ann Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Salisbury 29971 Deer Harbor Drive If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X 89 07/20/1922 214-12-5115 Maryland **Director** Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 USA 29971 Deer Harbor Drive items ? death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 Married than "natural", or Maryland 21215-0036 72 hours after Completed by ☐ Yes 1 Yes 2 X No Specify: If Yes, Give Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Health Care Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ruth Lee Travers Oswald Wilkinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Mitchell Jr/Son 1 and 2 sl if Health a item 27 i 29971 Deer Harbor Dr., Salisbury, MD 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ţ Important: If its any injury or of Wicomico Memorial^e, Park 1 X Burial 2 Cremation 3 Removal from State 4/2/2012 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 Signature of Funeral Service Licensee Compson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or linjury Due to (or as a consequence of): Exami the attending physician and hed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown q | Unknown by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 24 hours after death.

Funeral Director: After this certificate 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at wo<u>r</u>k? Certificate: 1/ Natural 5 Pending 2 🗌 No 1 Tyes 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier

State

Registrar

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31. Date filed (Month, Day, Year)

1205

0. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give Examiner Draw Funeral of Birth eigi 01/18/1932 80 **1**X M 2 □ F Director 578-72-7118 Haiti show "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Hyattsville Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Important: If item 27 is marked other than any injury or other than 1. Funeral USA 20783 8526 Adelphi Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Bace - American Indian. Armed Forces' Black, White, etc. 1 Never Married 2 XMarried Completed by 2 XNo Black 1 ☐ Yes 2 ☐ No Specify: Yes. Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Silver Spring Elementary/Secondary (0-12) College (1-4 or 5+) Chef 12 Sheraton Hotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elzira Estelus Darius Mondestin 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6101 Edsall Rd. Alexandria, Va. 22304 Barbara Mondestin (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X cremation 3 Removal from State 04/13/2012 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licenses 22. Name and Address of Facility Rendon/Hale Funeral Home <u>9013 Annapolis Rd. Lanham, MD 20706</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final nset and Death Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or injury that initiated events and resulting in death) Last physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months? Month Pregnant at time of death Unknown be detached 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy death? 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician; filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🔀 No Other: 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🕅 Natural work? 5 Pending injury Investigation
6 Could not be 2 🗌 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Experimer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nur only on Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signaty title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 36 ddress of person who completed cause of death (Item 23a) (Type, Print) 20010 Century Blvd. Germantown, MD 20874 James Rosenthall, MD 3.1. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marie Inez Sidberry Johnson McCreary 2012 March 31 1:18 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges 3837 Sunflower Circle Bowie Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 🗆 M 2 🗶 F Days April 21,1948 Washington,D.C. Months Hours Min 579-62-3525 Yrs **Director** 63 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20721 United States 3837 Sunflower Circle 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. **Black** 3 - Widowed 4 - Divorced Specify: Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) U.S.Department Elementary/Seconday (0-12) College (1-4 or 5+) 3 years Accountant of Interior marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ပ္ .. Page 1 and 2 should be trnent of Health and Ments tant: If item 27 is marked jury or other traumatic e Anderson Effie Stanley Sidberry 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rocellous Franklin McCreary, Jr. 3837 Sunflower Circle; Bowie, Maryland 20721 , 2012 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 Department of Important: If it any injury or o X Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, 4 ☐ Donation 5 ☐ Other (Specify) Maryland Cheltenham Veterans Cemetery Maryland CC0333 22. Name and Address of Facility ${\bf R.}\,\,{\bf N.}\,\,$ Horton Company Morticians, of Funeral Service Licenses 0 Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Metastatic Breast Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Exam Cause (Disease or iinjury that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) nding physician use as the burial Physician/Medical Box 68760 IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
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To the Funeral Director: After this certificate I completed filled in by the funeral director, page To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 🕱 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: 1 🗶 Natural injury 5 Pending 1 Yes Accident Investigation 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) Kouestchou, mi) Jocetyne 163748 April 3, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, M.D.; 4041 Powder Mill Road; Suite 600; Calverton, Maryland 20705

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State Registrar 32. Registrar Signature

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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the but	Medical	(Check 2	Medical E	Physician: To the lixaminer: On the ba	sis of exam	ination and/	or investi	gation, in my op	inion, death o	ccurred at	the time, date	and place,	and due t	to the caus	se(s) and manner	stated.
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20			Fh						3446			4	.1.12			
4		30. Name and addre	ss of person of FAR	who completed cau	se of death	(Item 23a)	(Type, P	rint)	Road	su.to	200	Calo-	14	MA	20769	
	ate	31. Date filed (Month	n, Day, Year)	AHIFAR 32. F	Registrar's	Signature	1	·/- · · ·	,	,		J 1246	<i>,</i>	. 0 .	,,,,	
Regist	rar	APRU	52012	(known)	P	gar										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 2012 10:05AM Polly Lee Phillips Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10346 Caleb Rd. Worcester in . Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🖾 F Months Days Hours Min. 89 Director 218-20-5038 4 Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sl notified 1 ☐ Yes 2 🎦 No MD Worcester Berlin 10e, Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ems 23a or r must be Funeral 10346 Caleb Rd. 21811 USA items hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status "natural", or ite Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates white Completed 3 Widowed 4 Divorced th and Mental Hygiene. 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Education 04/08/12013 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Lee Insley Pauline White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other troones. Susan DeGroft / daughter Burley St., Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State St. Paul's Cem. 4/5/2012 4 ☐ Donation 5 ☐ Other (Specify) Berlin, MD 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown 1 Yes 2 9 Unknown be detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Hospital or Attending Physician: The law autopsy performe this certificate has the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manger of Death 28b. Time of 28c. Injury at work? 1 □ Yes 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No within 24 hours after death. To the Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by Homicide determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practice. (Check 29b. Signature and title of certifie ac. License number 29d. Date signed (Month, Day, Year)

Registrar

Name and address of

100/40 God

person_who completed cause of death (Item 23a),(Type, Print)

5 201

gistrar's Signature

12-02617 Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 12306

		1- For State Registrar	Certific	ate of Dea	nth	Re	eg. No.	
Physic		1. Decedent's Name (First, Middle,Last)				Date of Deat Month	Day Year	3. Time of Death
Medical Exan	ninei	Cuong Van Pha 4a. Facility Name (if not institution, give		Late Oile	Town and another (Day	April 1, 20	12	1855 hrs
		Washington Adventist Hosp			, Town, or Location of Dea oma Park	ım	4c. County of Death Montgomery	
Funera		Social Security Number 6. Sex	7. Age (In yrs. last bir		der 1 Year If Under 24H		h(MM/DD/YYYY) 9. Birt	
Directo	r	578-19-0437 1 <u>×</u> 1	1 2 F 41	Yrs. Mont	ths Days Hours M	^{in.} 12/31/	1970 Foreig	n untry)Vietnam
A	1	Usual Residence of Decedent 10a, State 10b, County	10.00					
ow any		1.52. 55411,	10c. City, Town	rdale				10d. Inside City Limits 1 X Yes 2 No
rryland Sa-f show	ă	Maryland Prince Ge 10e. Street and Number	orges Rive		ip Code	140	g. Citizen of What Cour	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. It is marked other than "natural", or items 23a or 23a-f sho artic event, the Medical Examiner must be notified at once	Director	6279 64th Avenue			0737		Vietnam	u y :
with t	<u></u>		12. Was Decedent Ever in U.S.		dent of Hispanic Origin? (can Indian, Black,
death or iter	Funeral	1 X Never Married 2 Married	Armed Forces? 1 Yes 2 No	If Yes, spec	cify Cuban, Mexican, Puer	to Rican, etc.)	White, etc.	tnamoso
s after ral",	<u>ج</u>	3 Widowed 4 Divorced	r Dates:		2X No specify:		Specify:	etnamese
hour: "natu Exan	te d	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	College (1-4 or 5+)		il Occupation (Give kind o orking life. DO NOT use re		16b. Kind of Business/I	ndustry
036 thin 72 than	Completed	8	Sollege (1 4 of 5.)	Unknown			Unknown	
5-06 led with Hygier other	5	17. Father's Name (First, Middle, Last)				ne (First, Middle, M	laiden Surname)	
21215-0036 Mottal Edited within 7 Mental Hygiene. Beent, the Medical	Be	Hung Vo			Lan Pr			
MD 2' d 2 should lth and Mu n 27 is ma	2	19a. Informant's Name/Relationship (Typ	100		s (Street and Number or			Zip Code)
Mark Surger		Chi Thi Pham (Sist 20a. Method of Disposition	,	2/9 64th of Disposition (Na	Ave. Rivero	Date MD	20 / 3 / 20c. Location - City or	Town State
Baltimore, permit. Pages 1 an Oppartment of Hea Important: If ite injury or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other training or other tr		1 Burial 2 Cremation 3	Removal from State cremat	tory or other place	e)	l	•	
Baltimo permit. Page Department c Important:		4 Donation 5 Other Specify: 21. Signature of Funeral Service Linery e		peake Cr	ematory 04/	T0/20T2	Beltsville,	, MD
Department of the partment of	U	Millen 50	ud		Annapolis Ro			idie
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/Medica Examine			ocaine Intoxicat	ion and	Alcohol Use			Between Onset and Death
zamino	m n	or condition resulting in death)	e to (or as a consequence of):					
	9	Sequentially list conditions, b if any, leading to immediate Du	e to (or as a consequence of):					
	Examiner	(Disease or injury that initiated c.						
cecuted		events resulting in death) Last Dt. d.	e to (or as a consequence of):					
Box 68760, death certificate be executed the attending physician and of for use as the burial - transi	/Medical		AMENDED 23a, 27, 28a-	-f,per m	e,g928 6-21-	·12 sm		
760, cate be ex physiciar the burial	Med	IF FEMALE:	23c. If yes, outcome of pregnancy				23d. Date of delivery	_
687 certific		23b. Was decedent pregnant in the past 12 months?	1 Live birth 2			ancy	Month D	ay Year
Box 68760, e death certificate by the attending physic ed for use as the bur	Physician	1 Vog 2 No 0 Unknown	9 Unknown	5 Other (Sp∈	ecify)			
that the detached detached		Part II. Other significant conditions co	entributing to death but not resulting	g in the underlying	g cause given in Part I.	23e. Did tob	pacco use contribute to t	he cause of death?
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tal Rec	ادة ا	25. Was case referred to medical			26.Place of Death (Check			
of Vital Records, R Physician: The law requir ther this certificate has been s neral director, page 2 should b	8	examiner? 1 ✓ Yes 2 No	pital: 1	utpatient 3 🗌 [OOA Other Nursi	ng Home 5 R	Residence 6 Other:	
ling Ph After 1 funeral	Ë	27. Manner of Death 1 Natural 5 Panding	28a. Date of Injury (Month, Day, Year) 28b.	Time of Injury	28c. Injury at Work?	l _	ow injury occurred	
SiOr Attend death cctor:	cati	2 Accident S Pending Investigation		06:00 pm	1 Yes 2 X No	unknown		
Division of Vital Records, P.O. I To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detable	Certification:	3 Suicide 6 X Could not be determined	28e. Place of Injury - At home, fa (Specify) Found: R	arm, street, factory esidence	_	28f. Location (Story Town, Sta	reet and Number or Rur ate) 8528 11th	al Route Number, City Ave.
Hospit 4 hour Funer ely fill		29a Certifier	To the best of my knowledge, dea	ath occurred at the	e time, date and place, an		spring, MD.	
To the Hos within 24 h To the Fun completely	edical	one) 2 Medical Examiner: O	n the basis of examination and/or in ad manner stated					
FRES	ž	29b. Signature and title of certifier	a manner stated	29	c. License number		29d. Date signed (Mon	th, Day, Year)
		(mel			O.C.M.E.		April 2, 2012	
		30. Name and address of person who con	. , ,		25	D 04655		
			Medical Examiner 900 W	v. Baltimore S	otreet, Baltimore, M	U 21223		
S Regis	tate trar	31. Date filed (Month Pay Year) 12012	Julius D. Age	ake				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2012 Jay Phillip Palmer March 30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1814 Clayton Drive Oxon Hill Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign . Age (In yrs. last birthday **Funeral** 1**x** M 2 □ F Months Hours Princeton, W. Va. 07/14/1962 49 **Director** 579-80-2460 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at Director 1 Yes 2 No Md. P.G Oxon Hill 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a 1814 Clayton Drive 20745 U.S.A. or items hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married And Arried ð Maryland 21215-0036 If Yes, Give Specify: Black 1 Yes X No Specify. "natural", 3 Divorced Completed Vear or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than " Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed within f Health and Mental Hygiene. item 27 is marked other tha Brickmason Construction 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Hobbs Helen Palmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1814 Clayton Dr., Oxon Hill, Maryland 20745 Helen M. McAbee/Mother injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth 🖺 Burial 2 🗆 Cremation 3 🗋 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Heritage Mem. Cem. 04/06/12 Waldorf, Maryland ^{22. Name and Address of Facility}
Henry S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington D.C. 21. Signature of Funeral Service Licensee sall CC0316 23a. Part 1. Enter the asease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Right Bundle Branch Block Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year 1 Yes 2 g Unknown the P.O. 1 þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🙀 Yes 2 □ No 3 □ Probably 4 □ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: After this certificate 1 ☐ Yes 2 ☐ No Yes 2 No Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 1 Tyes 2X No ည 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) To the Hospital or Attending X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No М ☐ Accident Investigation within 24 hours after deat

To the Funeral Director:
completed filled in by the 3 Suicide 4 Homicide 6 Could not b Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determin Medical Continue Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica nination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b. Signature an 29d. Date signed (Month, Day, Year) MD13627 April 3,2012 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite # 103

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

APR 0 6 2012

parks

32. Registrar's Signature

Cleveland Williams, M.D. 2041 M.L. King, Jr. Ave., S.E., Washington, D.C. 20020

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3:33PM Physician/ Month APPIL 2012 GLADYS JUNE QUANN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CHARLES CWISTA PLATA MEDICAL CENTER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex If Under 24 Hrs. **Funeral** (Month, Day, Year) 3-18-1925 Months Days Hours Min 1 🗆 M 2 🗐 PETTRY, W. VA. Director 232-44-2408 87 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Tes 2 X No CHARLES LA PLATA MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20646 7878 WICKER LANE U.S.A. items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Examiner ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 be filed within 72 hours after Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2x No Specify: SpecifyWHITE "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Ms Elementary/Secondary (0-12) College (1-4 or 5+) COUNTY DRUG STORE CLERK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ ALLIE LILLY GEORGE HIGGINBOTHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA TILLMAN-DAUGHTER 104 HALDANE CT. LA PLATA, MD. 20646 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 \underline{X} Burial 2 \square Cremation 3 \square Removal from State MT. REST CEMETERY 4-13-12 LA PLATA, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License M200479 22 ame and Address of Facilit RAYMOND FUNERAL SERVICE, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate
Interval Between
Onset and Death
Can be and Death Immediate Cause (Final Ph sician/ NA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury Examine Due to (or as a consequence of): signed by the attending physician and defected for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No 5 ☐ Other (specify) Month Day Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been sig completely filled in by the funeral director, page 2 should to map the funeral director, page 2. Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a, Was an autopsy performed? Yes 2 \(\frac{1}{2}\) No Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital Other: 1 🗌 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 7. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation Accident 2 Accident
3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🗏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the cause of my confederable death occurred at the time, date and place, and due to the cause(s) are manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO

Registrar

State

GLADYS

6934 AVIATION BLVD, SUITEB, GLEN

BURNIE, MD 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 25, per me, g926 4-30-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month PRIL Physician/ Gennaro Joseph Rizzo 2012 :50 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SINT AGNES None +DSPITAL TIMERE Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth Month, Day, Year May 3, 1945 Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F Days Min. 218 48 4334 Yrs 66 **Director** Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified 1 XYes 2 No MD None Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10 N. Rock Glen Road 21229 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 6 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: "natural", 3 Widowed 4 Divorced Specify: Completed White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Disabled N/Apermit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, ? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Rizzo Ernesta Valenti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank J. Roso/Cousin 3648 Cragsmoor Road Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 4 🗆 Donation 5 🔀 Other (Specify)entombment 4-6-2012 Baltimore, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. oproximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition ASPIRATION OF LAIVAISA Medical resulting in death) Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDIC SYLAMINER Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events 2 The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Yes 2 No the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FAIL 1 ☐ Yes 2 № No 3 ☐ Probably 4 ☐ Unknown page 2 should CHRONC . Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page DIABETES 2 No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Division of Vital examiner? Hospital: 1 X Yes Other: Certificate: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident work? 1 ☐ Yes 2 ☒ No 5 Pending APRIL 3 2012 UNKNOWNM CHOKING Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10 N ROCC (Jenn Rd Baltimo Baltimore, U Medical 1 🔀 Certifying Physician: To the best of my knowless, e, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Gertifying Nurse Practioners To the best of my knowledge, deet 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D70718 2011 MD FPRIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 CEDRIC DARK CATON AVENUE BALTIMORE 700 SOUTH MD 31. Date filed (Month, Day, Year) 32. Hegistrar's Signature State APR 06 Person. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month John Albert Russell 20:57 M MACI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HICOMICO YENINSHIA Mediene SAUS6414 REGIONAL If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8 Date of Birth **Funeral** Min. (Month, Day, Year) **Director** 1 **X** M 2 □ F 218-48-8287 62 -24 - 1949MD 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No MD Wicomico Salisbury 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 25925 Porter Mill Road 21830 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: and Mental Hygiene. 3 Widowed 4 XDivorced Year or Dates. Navy Specify:Black Completed the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Wicomico Co College (1-4 or 5+) Teacher Bd of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Albert Russell Mildred Lee Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 st tment of Health a tant: If item 27 is Mildred Russell/Mother 959 Gateway Street, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 s
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3-31-2012 | Hebron, MD Spring Hill Gard 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith 917 W. Isabella St. Salisbury, MD 21801 Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be the IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death ed by the at detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy certificate 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other 1 Yes 2 1400 ည 1 Impatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director: After this filled in by the funeral d 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) injury Natural 5 Pending 1 ☐ Yes 2 ☐ No. 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral Completely filled Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number D 73353 03-26-12 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 111 Carroll St. Salisbury Sravanthy Pataparla 100 E. Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March March Physician/ 30, 2012 P^{M} 7:15 Hazel Baugher Don Russello Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Laurel Cherry Lane Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth June 12 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 🗆 M 2 🛣 F Virginia 101 1910 **Director** <u>579-48-5479</u> Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 313 Old Line Avenue 20724 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) People's Drug Store Clerk 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental George W. Baugher Ama Eliza Baugher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important; If item 27 is any injury or other trau 313 Old Line Avenue, Laurel, MD 20724 Ralph E. Brignac / Grandson Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/4/2012 Elkton, Virginia Elk Run Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 On Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Over 3 years Immediate Cause (Final Physician/ Alzhiemer's Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury death certificate be executed as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 IF FEMALE ase s 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 X No Month Year Day Pregnant at time of death been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Arterio Sclerotic Cardiovascular Disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No ည 1 Inpatient 2 I ER/Outpatient 3 I DOA

Hospital or Attending Physician: The law 24 hours after death.
Funeral Director. After this certificate has eted filled in by the funeral director, page 2. Division of Vital To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completed filled in by the fu

Certificate:

Medical

27. Manner of Death

X Natural

2 Accident

4 Homicide

29a. Certifier

(Check

Syed A.

only one)

29b. Signature and title of

,32. Registrar's Signature 31. Date filed (Month, Day, Year, Registrar

Sadiq,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14333

5 Pending

Investigation 6 Could not be

determined

28a. Date of injury (Month, Day, Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at work?

🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Laurel Bowie Road, Suite 208, Laurel, MD 20708

1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D24721

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

March 31, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 04/01/2012 5:30A M <u>Francisco Negron Reyes</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Silver Spring Holy Cross Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7/2271931 Director 60 583-42-8779 1 🔀 M 2 🗆 F Puerto Rico Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Takoma Park MD Montgomery 10e. Street and Numbe 10f. Zip Code ö 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 20912 7667 Maple Ave #306 United States Page 1 and 2 should be filed within 72 hours after death Was Deceus.
Armed Forces?
Ves 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 No Specify: Puerto Rican Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance Private of Health and Mental Hygie f item 27 is marked other r other traumatic event, tl Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7667 Maple Ave #306 Takoma Park, MD 20912 Sobey Osorio - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 🕱 Burial 2 □ Cremation 3 □ Removal from State Silver Spring,MD 4/10/12 4 Donation 5 Other (Specify) Gate of Heaven 22. Name and Address of Facility W.H.Bacon Funeral Home 21. Signature of Funeral Service Licensee 20010 3447 14th St., NW Washington, DC Vanda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Respiratory Failure Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Metastic Spindle Sarcoma Secule attally liet in a filtrarie if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death □ Yes ≥ L 9 Unknown P. 0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 🗌 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 X Natural 5 Pending Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the the within To the

State Registrar 29b. Signature

and title of certifie

Jonathan Duran

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500

32. Registrar's Signatur

٩

29c. License number

D66249

Forest Glen Road Silver Spring, MD

29d. Date signed (Month, Day, Year)

4/2/2012

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
amend 15 per fb, g926 4-17-12 sm
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death Пау Month Physician/ RAJOTTE 201 LUCIEN THOMAS Apri Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Timonium Stella Maris Hospice 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 5, Social Security Number 6. Sex Funeral Months Days Hours 036-01-2838 Director **X** M 2 □ F Yrs 88 Rhode Island Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location Director 1 Yes 2 No Jarrettsville MD. Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21084 3759 Jarrettsville Pike United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify Specify. White 3 Divorced 4 Divorced Year or Dates. WW 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Advertising Commercial Artist 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Valida Beauregard Rajotte Victor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21050 19a. Informant's Name/Relationship (Type, Print) Forest Hill, MD. 1814 Grafton Shop Rd. Karl Rajotte (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 10, cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Jarrettsville. MD. Jarrettsville Cem 22. Name and Address of Facility E.G. Kurtz & Son Funeral Signature of Funeral Service Mcensee blackten Jarrettsville, Maryland Home. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ COLON CANCER disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) be detached for in the past 12 months? Month Day Pregnant at time of death 2 🗌 No After this certificate has been signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, director, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy
performed?

Yes 2 X No prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 2 **X**No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28d. Describe how injury occurred X Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 24 hours after deatl Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) the within 7 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AN **CRNP** 2300 DULANEY VALLEY RD. TRACIE L. MORGAN, TIMONIUM, MD 21093 31. Date filed (Month, Day, Year)
APR 1 7 2012 State Registrar

2012

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RAJOTTE

LUCIEN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1650M Physician/ Shirley Eva Story 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Easton Memorial Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Hours 219-56-8641 Usual Residence of Decede Director 1 🗆 M 2 🗶 F 11/19/1935 Maryland 76 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director nit. Page 1 and 2 should be filed within 72 hours after death with the Maryla adtrement of Health and Mental Hyglene protrant: If item 27 is marked other than "natural", or items 23a or 28a-f s injury or other traumatic event, the Medical Examiner must be notified. 1 X Yes 2 No Denton Maryland Caroline 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21629 904B Gay Street Edenton Manor 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 2, 1 Yes 2 ANO If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3

Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Family Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred May Harris Department of Health and Month Important: If item 27 is marked any injury or any injury or any injury or any injury or any James August Brogley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21629 Denton, Maryland 801 Caroline Apartments Helen Coultas/daughter Baltimofe, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4/9/2012 Hurlock, Maryland Eastern Shore Veterans Cemi. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee
Kaudby Moore Funeral Home, P.A. 22. Name and Address of Facility 12 South 2nd Street Denton, Maryland DOM 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ Due to (or as a consequence of): Yulmonary Edema disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last attending physician a الا أماد الله as the burial-Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav Year 1 Yes 2 • 9 Unknown the Unknown signed by the Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Hypertens:on 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No melli 24a. Was an page 2 s autopsy Hospital or Attending Physician: The 24 hours after death.
 Funeral Director: After this certificate if Paraxysmal 25. Was case referred to medical 26. Place of Death (Check only one) completely filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 0 No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 1 🔲 Yes 2 🔲 No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier l 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I 29b. Signature and title of g 29d. Date signed (Month, Day, Year) D72893 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TelClerm Chael, Ghernet 21 219 5 Mashington St, Easton MD. 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 06-2011

State

Registrar

APR () Q

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 201^{Yea} Shelton Harry Schulties 9:30 P M April Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Caroline Caroline Home for Hospice Denton 9. Birthplace (State or Foreign Country) Maryland Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth Hours Min. 1 🛛 M 2 🗆 June 2 1924 Director 222-16-6594 87 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Maryland Caroline Greensboro 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 106 Hobbs Street 21639 death 1 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates. 19 45-46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ral", or iten Examiner 14. Race - American Indian. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Truck driver County roads system of Health and Mental Hygi item 27 is marked other other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Schulties Bertha Killen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 21639 Genevieve Schulties/ wife 106 Hobbs Street; Greensboro, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 X Burial 2 Cremation 3 Removal from State Apr 4 2012 4 Donation 5 Other (Specify) Greensboro Cemetery Greensboro, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 Fleegle and Helfenbein Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwe shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death SEMENTIA Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Jause (Disease of linjury the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year 5 Other (specify) 1 Yes 2 g been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENALINSUFFICIENCY, DIABETES Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Unknown ARIAL FIBRILLATION. DYSLIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h ATHEROSCHRATIC CARDIOVAS CULINO DISEASE performe 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident
Suicide
Homicide Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check only one

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ATTENDIALG MU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 70 17 10:30PM Irail APCI Medical 4a. Facility Name (if not institution, give 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Somerford Place Columbia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Hours 556-58-5708 Director **№** M 2 🗆 F Yrs 75 11/02/1936 Tran Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Ellicott City 1 Yes 2X No 10e. Street and Number 10g. Citizen of What Country? by Funeral 9742 Michaels Way 21042 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces? 1 ☐ Yes 2 🛂 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Engineer WR Grace Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ali Akbar Marzieh Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia H. Saleh - Wife 9742 Michaels Way Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Ardent Crematory 04/07/2012 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Callins 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line End-Stage Dementia Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last the burial-trai Due to (or as a consequence of) attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month Year the a signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 performed? Yes 2 No certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Fother Specify FACILITY 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

MSNW WPW 14MD 29c. License number 0 005 7465 29d. Date signed (Month, Day, Year) 415/17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASNA) APAKS MD 2835 Sm III /N Baltimore MD 21209

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

APR 06

32 Registrar's Signature

			State of Maryland / Department of Healt		ntal Hygler	ie -	
			Registrar Certificate of Deat		Reg. I	No.	T
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Sidney Lee Smith	2		Day Year	3. Time of Death
	Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Locati			4c. County of Deat	
19-	/. 		77 C 7 C 7 C 7 C 7 C 7 C 7 C 7 C 7 C 7	0474 nder 24 Hrs. 8	. Date of Birth	Wicomi	
	Funeral Director		210_18_6605 Months Days Hou		(Month, Day, Year	r) 9. Bin Coa	hplace (State or Foreign untry)
			Usual Residence of Decedent	(03/03/192	25 Ma	ryland
	land sho	to	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Mary 28a-1 otifie	irec	Maryland Wicomico Salisbury				1 X Yes 2 ☐ No
	death with the Maryland items 23a or 28a-f sho ner must be notified at	eral D	10e. Street and Number 1101 S. Schumaker Drive 10f. Zip Code 21804		10g.	Citizen of What Co USA	untry?
ار 2036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ X Yes 2 □ N Coast If Yes, Give Year or Dates. 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex Yes 2 ☒ No Spe		/ Yes or No- an, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
Smith d 21215-0	in 72 ho e. nan "nat Medica	omple	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during r	most of working		. Kind of Business/	Industry
∑ 7	with ygien her th	Be Co	12 – Printer			Printing	
L. Swith Maryland 21215-0036	d be filed vental Hygarked oth	To B			irst, Middle, Maide ane Lentz		
	d 2 should alth and Μ n 27 is mar er traumati		19a. Informant's Name/Relationship (Type, Print) Sophie Smith/Spouse 19b. Mailing Address (Street and Nu 1101 S. Schumak	umber or Rural Ro Le Dr, 1	oute Number, City Apt • 209	or Town, State, Zip Salisbur	y,MD21804
S, dheb	Page 1 an ment of He ant: If iten ary or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory	Date 7 4/3/20	ı	Location - City or	
S	permit. F Departm Importa any inju		21 Signam of Fig. S. wice Licensee 22, Name and Address of Fig. Holloway Fun 501 Snow Hill	1			
	MANUAL CON		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.			77 110 210	Approximate Interval Between Onset and Death
	Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of:				
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):				
	cate be executed physician and s the burial-transit	edical Examiner	Cause (bisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			11.1	
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89	certifica nding p use as		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of del	ivery
Box (he death y the atte ached for	Physician/N	230. Was december pregnant 1			Month	Day Year
ls, P.C	requires that the death certifica been signed by the attending p should be detached for use as	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F	Part I.			the cause of death?
Division of Vital Records, P.O.	The law ate has page 2	Completed			24a. Was an autopsy performed 1 Yes	prior to o	topsy findings available completion of cause of
ital	sician: The certificate irector, pag	Be	examiner? Hospital: Other	Death (Check on		_/	11-01-00
5	Phys r this eral di	2:	1 Inpatient 2 ER/Outpatient 3 DOA 4 27. Maymer of Death 28a. Date of injury 28b. Time of 28c. Injury at			ury occurred	the later
n c	nding ath. : Afte e fune	icate	Natural 5 ☐ Pending (Month, Day, Year) injury work? Accident Investigation M 1 ☐ Yes (2)	l l	50001150 11011 111	ary occarrou	
ivisio	l or Atter after dea Director	Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f	Location (Street a City or Town, Sta	and Number or Rui ite)	ral Route Number,
	To the Hospital or Attending Physician: " within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical	29a. Certifier Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deal	ath occurred at the	time, date and pla	ce, and due to the	cause(s) and manner stated.
	To the ithin 2 To the omple	Σ	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time 29b. Signature and title of certifier 29c. License numb	ber		ose(s) and manner a Date signed (Month	
	~10		30 Name and address of person who completed cause of death (Item 23a) (Type Print)		3	31/12.	
25	VIVA		30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) YO RESIA VO HRA 910 EASTERN SHORE DR., S	SALISB	URY, MD	, 21804,	
	Sta Registra		31. Date filed (Month, Day, Year) APR 0 4 2012 33 Registrar's Signature				•

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ 9:54 \mathbf{P}_{M} Kenneth Edwin Saylor April Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Caribbean Breeze Assisted Living Huntingtown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min (Month, Day, Year) 536-32-6550 Director 1 ☒ M 2 ☐ F 76 June 28, 1935 Washington, DC shov 10a. State 10b. County 10c. City, Town or Location the Maryland rector ms 23a or 28a-f s must be notified 1 Yes 2 X No Maryland Calvert Owings 這 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20736 USA 7926 Niagara Court within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner rmed Forces?
No NAVY Black, White, etc. or i 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1953–1957 1 ☐ Yes 2 🛣 No Specify: Specify: White "natural", 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) John F. al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Kennedy Center the Stage Manager 12 Be and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ! ပ Edwin Emory Saylor Mildred Irene Lyddane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7926 Niagara Court, Owings, MD 20736 item 27 Irene M. Sampson / Daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 20 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4/4/2012 Brentwood, Maryland Fort Lincoln Cemetery 4 Donation 5 Other (Specify) 22, Name and Address of Facility Signature of Funeral Service Licenses 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Laryngeal Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** 2 Weeks Aspiration Pneumonia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be after death. P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disease 1 X Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed been Cerebrovascular Accident 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 death? certificate 2 X No 1 🗌 Yes 2 No ☐ Yes 26. Place of Death (Check only one) funeral director. 25. Was case referred to medical Be examiner? Hospital 1 ☐ Yes 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 4 ☐ Nursing Home 5 ☐ Residence 6 🕱 Other (Specify this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred s after death. I Director: After t (Month, Day, Year) injury work?
1 Yes 2 No 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by determined building, etc. (Specify) City or Town, State Hospital within 24 hours To the Funeral Medical 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -D62090 4/3/2012 fra Mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stanley John Wisniewski, M.D., 8191 Jennifer Lane, Suite 150, Owings, MD 20736 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 2012 1330 Richard J. Stahl, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ceci1 458 Old Field Point Road E1kton Social Security Number Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ Months NOV 2 Day, Year 45 Hours Michigan 372-44-9024 Director 66 Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland at 10d. Inside City Limits Director 27 is marked other than "natural", or items 23a or 28a-f's traumatic event, the Medical Examiner must be notified 1 Yes 2 X No Maryland Ceci1 E1kton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 458 Old Field Point Road 21921 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 1 Yes 2 No
If Yes, Give Black, White, etc. ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1984 1 ☐ Yes 2 ☒ No Specify Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. United States Elementary/Seconday (0-12) College (1-4 or 5+) Equipment Specialist/Program Manager Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental marked 2 Richard H. Stahl Carol E. Filion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Linda L. Stahl/Wife Post Office Box 705, Elkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any Injury or o
once. 1 Burial 2 X Cremation 3 Removal from State R. A. Ferris & Co., Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2012 West Chester, PA 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical requires that the death certificate be Box 68760 as the l IF FEMALE nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No detached for Pregnant at time of death Month Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ. Division of Vital Records, 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? certificate 1 Yes 2 No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Tes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MD D0062190 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ KHAN AUGUSTINE 2533 HERMAN HWY SUITEA, CHESAPEAKECITY MD 21915

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

3 2012

APR 1

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 540 Ethel G. Sweitzer April Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ceci1 Abbey Manor Assisted Living E1kton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9 Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday **Funeral** Year) 916 SEPT 23 Wisconsin 95 390-09-6300 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location "natural", or items 23a or 28a-f sho 72 hours after death with the Maryland Director 1 X Yes 2 No E1kton Marvland Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Colonial Manor Court United States 21921 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11, Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes Give Specify. 3 X Widowed 4 Divorced White Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) the In Her Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ella Vornholt Arthur W. Forsberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7152 Savoy Court, Seminole, FL Richard F. Breske/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Agnes
Catholic Cemetery 20c. Location - City or Town, State 20a, Method of Disposition April 11. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or Cemetery 2012 Ashland. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hicks Home for Funerals, P.A. ire of Funeral Service Licensee 21. Signal 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARKINSON Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 signed by the a d be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filed in by the funeral director, page 2 s. performed? Yes 2 X No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural _____vatural ☐ Accident ☐ Spic' 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062190

State Registrar

DHMH 17 Rev 7/2009

, SUITEA, CHESAPEAKE CITY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ KHAN MD HERMAN HWY

32. Registrar's Signature

AUGUSTINE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Month OZ-Thomas Truitt Kenneth 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1Comico 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Min **Director** 219-70-8300 1 **X** M 2 □ F 55 1-21-1957 Maryland 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Somerset Eden 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21822 USA 4079 Skylar Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian "natural", or ρ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Himore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Year or Dates White injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 land Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Landscaping Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Beasley | Thomas Truitt Virginia William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra 2729 Lake Whatcom Blvd. Bellingham, Washington 98229 Ronnie T. Truitt - Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, 4-4-2012 Delmar, Delaware Crematory of Delmarva Signature of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ MALIGNANT CANCER OF UNKNOWN disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or se a consequence on): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? Day Pregnant at time of death been signed by the a should be detached Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autops performe Yes 1 Yes funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 21 No 405PICE မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence After this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natura injury 5 Pending ours after death.

leral Director: Aft
filled in by the fur 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined Medical within 24 hou

To the Funer

completely fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Sertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 10058400 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Uh WARE 20 1300 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State
Registrar Amend #29d per DME 4/6/Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Month Physician/ Claretha Warren Taylor 2:05 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince Georges Hospital Center Cheverly Prince Georges Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 1932 g. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours Min **Director** 224-34-6497 1 - M 2 X F April 11 Virginia Usual Residence of Decedent show 10a. State 10d. Inside City Limits 10c. City. Town or Location notified at Director 28a-f 1 X Yes 2 No Maryland Prince Georges Glenarden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 20706 8659 Glenarden Parkway United States items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-"natural", or iten edical Examiner r 14 Race - American Indian Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes Give **Black** 3 X Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. U.S. Department of Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Housekeeper State and Mental Hygie is marked other event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and.

of Health and

frem 27 is mann.

rraumatic ev. ပ Booker Warren Della Holloman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Gloria Ann Taylor (Daughter) 8659 Glenarden Parkway; Glenarden, Maryland 20706 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)

April 11,2012

National Harmony Memorial Park

Landover, Maryland 4 Donation 5 Other (Specify) 21. Signature of neral Service Licensee 22. Name and Address of Facility R. N. Horton Company Morticians, CC0333 Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ LNMA Medical resulting in death) Due to (or as a consequence of) Examiner munio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in these to the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause Due to (or as a consequence of). Exami BUST. use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Box 68760 res, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death been signed by the a should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2-No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed page 2 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) <u>1</u>0 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury
(Month, Day, Year)

Mroll 30, 2 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1-2 injury 33 M 5 Pending ☐ Natural Accident 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) nours after death.
neral Director: A
y filled in by the fi Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) **Glenarden, Maryland** determined dayliter home 8659 Glenarden Parkway Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of contifie 29d. Date signed (Month, Day, /3/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tsion Berhane, M.D.; 3001 Hospital Drive; Cheverly, Maryland 20785 31. Date filed (Month, Day,) APR 0 6 2012 State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Calvin April 1, R. Thompson 2012 6:30 p M Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore Social Security Number If Under 24 Hrs Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Director 218-14-5846 1 3M 2 F 90 11/13/1921 MD show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at **Funeral Director** 10d. Inside City Limits or 28a-f MD Baltimore Parkton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 1210 Mount Carmel Road 21120 USA death 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc ö 1 Never Married 2 XMarried by permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or amy injury or other traumatic event, the Medical Examinance. Baltimore, Maryland 21215-0036 Yes, Give 2 XNo 1 Yes 2 XNo Specify: Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) supervisor State Roads Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Clarence Thompson Minnie Belle Kemp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia May Thompson, wife 1210 Mount Carmel Road, Parkton, MD 21120 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State St. Paul's Cemetery 4 Donation 5 Other (Specify) 4/6/2012 Arcadia, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home 934 S. Main Street, Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Valvular Immediate Cause (Final Ph_{si}ian disease or condition resulting in death) Zasz Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Drie to for as a pusseouring, of as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 inding p use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day 1 Yes 2 Unknown the s P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown is certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Tes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28h Time of Injury at 28d. Describe how injury 24 hours after death. Funeral Director: After Natural 5 Pending work? 1 🔲 Yes 2 🗌 No Accident Investigation 6 🗌 Suicide Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F only one) 3 ... Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signat nd title of certifier 29d, Date signed (Month, Day, Year) 2012 OW

Registrar DHMH 17 Rev 06-2011

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APR 1 9 2012

HANVER

32. Registr r's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 23a & Pt II per med cert G926 4/2//12 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ Year 6:05 PM Hermione Victor 2012 Medical 4a, Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death COASTAL HOSPICE AT The SHISBURY Wicomico LAKE . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday, Days Hours 217-30-7660 **Director** 1 □ M 2 🙀 F 82 April 2,1929 MD Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 316 Maryland Avenue 21801 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 African-1 Yes 2 XNo Specify. 3 Widowed 4 Divorced Year or Dates American other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Laborer Poultry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacob Lee Victor Marie Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other traus Barbara Victor/daughter 316 Maryland Avenue, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Green Acres Mem Park 3/30/2012 Salisbury, MD Signature of Funeral Service Licensee 22. Name and Address of Facility
Lewis N. Watson Funeral Home, PA
1618 West Rd., Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph, i i n 60 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Examine Due to (or as a consequence of): for use as the burial-transit Cause (Disease or injury Chronic Lung Disease that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Day Month Year should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Dementia Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Mellitus 24a. Was an , page 2 s autopsy performed 1 🗌 Yes Yes 3 Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes No Other: Hashire ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) 1 Inpatient 2 I of 27. Manyfer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending Division within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 63199 3/24/12 310 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHORE DR. SALISBURY MO. 2184 OHRA 910 EASTERN 31. Date filed (Month, Day, Year) Registrar's Signature State 4 2012 Registrar

Victor

Hermione

			State of Maryland / Department of Health and Mental Hygiene
			1 - State Registrar Certificate of Death Reg. No. 20 2 232 (1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3. Time of Death
	Physicia Medic		Carl Henry Viers APRIL 19 2012 3 47 / M
	Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death
	Funeral Director		5. Social Security Number 234–24–0995 1 X 2 F 94 Yrs. Social Security Number 24 F 94 Yrs. Social Security Number 34 Social Security Number 34 Social Security Number 35 Social Security Number 36 Sex 1 Table 16 Sex 16 Sex 17 Security Number 36 Sex 17 Security Number 36 Sex 17 Security Number 37 Security Number 38 Social Security Number 38 Social Security Number 38 Social Security Number 38 Sex 17 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 39 Security Number 3
	Aaryland 8a-f shov tified at	rector	10a. State 10b. County Maryland 10c. City, Town or Location Manchester 10d. Inside City Limits 1 □ Yes 2 ☒ No
	with the h s 23a or 2 ust be no	Funeral Director	10e. Street and Number 5309 Hoffmanville Road 10f. Zip Code 21102 10g. Citizen of What Country? United States
9003	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ğ	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Yes 2 No Specify: white
Maryland 21215-0036	within 72 ho giene. er than "nat the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) truck driver 16b. Kind of Business/Industry construction
/land	d be filed Mental Hyg arked oth	To Be	17. Father's Name (First, Middle, Last) Pleasant Viers 18. Mother's Name (First, Middle, Maiden Surname) Fanny Ethel Nolan
, Man	d 2 should salth and N 27 is me	9	19a. Informant's Name/Relationship (Type, Print) Clenda B. Phillips/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5309 Hoffmanville Road Manchester, Maryland 21102
Baltimore,	0 = -		20a. Method of Disposition 2
Balt	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee M01072 22. Name and Address of Facility Eline Funeral Home 934 South Main Street Hampstead, Maryland 21074
	Physician/ Medical Examiner	er	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):
	cate be executed physician and sthe burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): d.
	requires that the death certifica been signed by the attending p should be detached for use as I	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1
rds, P.O.	equires that the been signed by the hould be detach	Completed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records,	The law ate has page 2	e Compl	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to predical
Vita	Physicial this certi ral directo	To Be	25. Was case referred to predical examiner? 1
n of	ding Pt h. After tf funera		27. Man of Death 28a. Date of injury Natural 5 Pending 28a. Date of injury 28b. Time of injury 28b. Time of injury at work? 28d. Describe how injury occurred
)ivisio	il or Atten s after deal Director: d in by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide 6 Could not be building, etc. (Specify) M 1 Yes 2 No 28t. Location (Street and Number or Rural Route Number, City or Town, State)
_	To the Mospital or Attending Physician: with 24 hours after death. To the Luneral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only on). Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	Vithi Com		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	10 km	2 3	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 ASNEEM (AKHAMI, MI) P.O. BOX 1525 (WINCK MI) 21117
Ť	Stat Registra		31. Date filed (Month, Day, Year) APR 1 9 2012 APR 1 9 2012

DHMH 17 Rev 06-2011

Carl "Vier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 25 per med cert G926 4/24/12 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 08:51 Am Za Anthony Eldridge Ward, Sr. 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** McCready Memorial Hospital Crisfield Somerset 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. (Month, Day, Year av 31, 1 11x M 2 Director 220-28-1822 78 MD Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Somerset Crisfield 1 Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 314 Cove Street 21817 USA items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i þ 1 Never Married 2 X Married ¹X☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 African-1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced Year or Dates American Injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner/Mortician Funeral Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leon Ward Dorothy Hearn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlene G. Ward/wife 314 Cove St., Crisfield, MD 21817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hopewell UMC Cemetery 4/7/2012 Crisfield, MD 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 21. Signature heral S any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Betweer Immediate Cause (Final nset and Death Physician eu MONI disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Unknown 2 🗌 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 \square Yes 2 No 3 □ Probably 4 □ Unknown Completed per Tension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Tes Yes 25. Was case referred to medical examiner? of Vital Be 26. Place of Death (Check only one) Hospital 2**X** No Other: မြ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manne of Death Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) injury work? 1 Natural 5 Pending Division death. 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation after deat Director: 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated id at the time, date and clane, and due to the Cartifying Nursa Practioner: To the best of my knowledge death consist 29b. Signature and title of certifie 29d. Date signed Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -The VF 31. Date filed (Month, Day, Year) State APR 0 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ O 4 Richard Alan Webster 2017 Medical 4a. Famility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1010LAL SALIS6414 HICOMICS If Under 1 Year | If Under 24 Hrs. Social Security Number **Funeral** Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 216-56-0517 **Director** 1 🕱 M 2 🗆 F 61 Yrs 07/27/1950 Maryland 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 312 N. Kaywood Drive 21804 USA Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 N Divorced Specify Completed White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 Pastor Religion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Virginia Ellen Kenney Richard Swain Webster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan L. Davis/Daughter <u> 27137 E. Lillian St., Hebron, MD 21830</u> 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🖺 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 4/3/2012 Salisbury, MD Sunature of Funeral Service Licensee Holloway Funeral Home Professional Association David H Dompoor 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician ASCUD disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) attending physician and for use as the bunal-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 g Unknown signed by the a Id be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed' Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗌 No Other: ၉ 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes To the Hospital r Attendent within 24 hours after death To the Funeral Director; the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) rertiving Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur 29d. Date signed (Month, Day, Year) 450497 4/2/12 of person who completed cause of death (Item 23a) (Type, Print) COTE HRISTOPHER SNYDER, 100 EAST CAKROLL STREET, SALISBURY, MD 21801 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh g927 5-11-12 vt

		-	For State Registrar	State of Marylar		arument of F tificate of E			Reg. No.		10000
		,	Decedent's Name (First, Middle, Las	t)				2. Date of De	ath	J 2 3.	. Time of Death
	Physicia Medic			bert W. Washin	gton				30, Day 2012		2:48 рм
	Examin	er	4a. Facility Name (if not institution, give Southern Maryla)	Location of Death	٦	4c. County	of Death ce Geor	ge's			
· wayson d	Funeral	_	5. Social Security Number 6. Se		ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th		(State or Foreign
	Director		3.7.30 1703	№ м 2 □ F 69	Yrs.	Months Days	Hours Min.	May 5	1943		OC
	nd show at	ū	Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo	cation	<u> </u>	liay 5,			Inside City Limits
	Maryla 18a-f stified	Director	DC			Wa	shington				1 ☒ Yes 2 ☐ No
	n the la or 2 be no	al Di	10e. Street and Number			10f. Zip Code			10g. Citizen of		
	th wit ms 23 must	Funeral	1229 G Street SE	Apt. 226 12. Was Decedent Ever in U.	0 110.1		003	a a city Voe or No		ted Sta	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 🙀 Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		Vas Decedent of Hi f Yes, specify Cubar □ Yes 2 🏋 No		o Rican, etc.)		ce-American Inck, White, etc. Africa America	an
5-(72 hou "nati	Completed	15. Decedent's Ed (Specify only highest gra		(Give I	lent's Usual Occupa kind of work done d	ation Juring most of wor	king	16b. Kind of B	usiness/Industr	у
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Maryland	2 shou th and 27 is m traum		19a. Informant's Name/Relationship (Ty Genieva Washingto		1	ng Address (Street a Halford					
	of Heal of Heal fitem 2		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of		il 6,		- City or Town,	
Baltimore,	Page ment c tant: If ury or		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Herrioval Horri Otate	Har	natory or other place mony	-	2012		ver, Ma	
Balt	permit. Page Department of Important: If any injury or once.	J	21. Signature of Funeral Service Liberts	7)560	Name and Addres	s of Facility St Benning			ome, In	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	ne cause on each line.	î.	Λ :	1. 1		rest,	Inte	proximate erval Between set and Death
and the last	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence)		Thung w	.M meta	interses			Set and Death
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	n #	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uanec of):						
	and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	uence of):				<u> </u>		
0	icate be executed physician and is the burial-transit	ledical		d .							
8760		Med	IF FEMALE:								
P.O. Box 68	The law requires that the death certific ate has been signed by the attending ipage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnanc Other (specify)	у			ate of delivery onth Day	Year
	ires that the dea signed by the a d be detached f	by	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.		obacco use cont		ause of death?
ord	w require s been si 2 should	Completed						24a. Was		Were autopsy fi	indings available
Sec	Physician: The law this certificate has al director, page 2	Som						autop perfo	rmed?	prior to comple death? 1 Yes 2 2	etion of cause of
<u> </u>	cian: ertifica ector,	Be (25. Was case referred to medical examiner?	Hospital:			ace of Death (Che				552
<u> </u>	Physic this c	٠ <u>.</u>	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 2	ER/Outpatier		4 ☐ Nursing F	lome 5 Resid			
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Division of Vital Records,	al or Attendir s after death. Il Director: Af ed in by the fu	Certificate:	3 Suicide 6 Could not be determined		ome, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Numbern, State)	er or Rural Rou	te Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check 2 Medica Frami	sician: To the best of my know ner: On the basis of examinatio	n and/or invest	igation, in my opinio	n, death occurred	at the time, date a	ind place, and du	e to the cause(s)	and manner stated.
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	81	9	30. Name and address of person who o	completed cause of death (Item	123a) (Type, F	Print) avenue S	E Sink	310 47	y huna ha	Doza	2032
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	Registra	ar	APR 0 6 2012 &	en D. pa	Ke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10e,19b, per fh g927 5-11-12 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 ear Physician/ Apr. 7 11:30 A M Norma Jean Wilson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Lorien Mays Chapel Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral ^{Year)}19<u>26</u> Hours NOV • 23 Months 212-26-8465 85 Maryland Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No MD Baltimore Upperco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral Mt. Carmel Road 21155 U.S.A. "natural", or items a 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black. White, etc. þ 1 XNever Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Manufacturing 10 permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, <u>tr</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John W. Wilson Bessie B. Trabert 490 Weiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carmel Rd. Upperco, MD 21155 Verna R. Diehl/Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 🛚 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place Middletown Cem. 4 Donation 5 Other (Specify) Freeland, MD Signature of Ineral Service Lic 22. Name and Address of Facility JJ Hartenstein Mortuary, 24 N. Second St. New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ neumoru disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ph Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this continued to the Funeral Director. burial-transit 15 mnits bral Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day ☐ Pregnant at time of death☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy nerform death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No 1 Yes Other: 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State, Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Cectifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only or 29b. Signature and the of certifier 29d, Date signed (Month, Dav. Year) RO79544 2012 Ogr 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) Sue Anthony 21204 STE 4105 MO CHAR LES 81 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 2012 10:44 P M Alisea Marie Sharon Medical 4c. County of Death
Howard 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Gilchrist Hospice Care Columbia . Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 213-86-9319 **Director** 1 □ M 2 🏋 F 51 Yrs. MD Oct. 07 1960 Usual Residence of Deced or 28a-f show notified at within 72 hours after death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Brooklyn Park 1 Yes 2X No Maryland Anne Arundel 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r Funeral 21225 USA 5312 Patrick Henry Drive items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, an "natural", or iter Medical Examiner Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2X No Specify. Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Megones. r than " the M Elementary/Secondary (0-12) College (1-4 or 5+) Hotel Facilities Manager 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Scones Lawrence Η. Alisea Doris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5312 Patrick Henry Drive, Brooklyn Pk, MD 21225 (daughter) Charlotte Nygard 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Aprilate 20 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc Baltimore, Maryland 4 Donation 5 Other (Specify) 2012 21. Signature of Funeral Service Licens 22. Name and Address of Facility Stallings Funeral Home, 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the d Part 1. Enter the disease, or comp shock, or heart failure. List only o ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death 2003 Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No Yes 2 No 1 🗌 Yes ours after death. eral Director: After this certifica filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other 1 Yes 2 No HOSPICE ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4

Homicide determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 164395 APRIL 19.2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 6336

DOBERMAN, MB

31. Date filed (Month, Day, Year,

CEPAR LANE COLUMBIA, MS 21044

12-02927 John G Arruda

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 12332

		1- For State Registrar		Certifica	ate of Dear	th			Reg. No.		
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ledical Exam	iner	JOHN G. ARRUDA			I ni Oil			April 14,	2012	of Dooth	19151118
\bigcirc		4a. Facility Name (if not institution, 4025 Frederick Ave, Ap	t 308		Baltii				4c. County		
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æ			stant Medical Examin	_		Street, Ba	altimore,	MD 21223			
S Regis	tate	31. Date filed (Month, Day Year) APR 2 0 2012	32. Registrar's	Signature							
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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2012 2325 Apri] Monica N. Betancourt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Gilchrist Hospice Columbia Columbia If Under 1 Year . Age (In yrs. last birthdav) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Hours Min. (Month, Day, Year) Director 1 □ M 2 👿 F 063-42-3472 Guayaguil Ecuador 4, 1938 73 May Usual Residence of Dece 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 No New York New York City ms 23a or must be n Ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 561 10th Ave. 10036 United States items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Examiner ō þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or 2**X** No Maryland 21215-0036 Yes If Yes, Give Year or Dates 1 XYes 2 No Specify: 3 🖁 Widowed 4 🗆 Divorced Specify: Hispanic Completed al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) Housekeeper Supervisor Hospitality 12grade traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gonzalo Viteri America Morange 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3362 N. Chatham RD. Apt. G, Ellicott City, MD. 21042 Tatjana Peribonio / Daughter other. altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury or Department of Important: If any injury or once. Druid Ridge Cemetery Apr. 19,2012 Baltimore, Maryland Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacAMBROSE FUNERAL HOME, INC. 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ a Mutostotic chriana disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it cay be cause. Enter Underlying Examiner Due to lor as a consequence of: or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of): ending physician a use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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To the I

comple only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) lan MOIO Date filed (Month, Day, State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Wilma Jean Bernardo 11:30 AM 2012 Medical 4c. County of Death **Examiner** Name (if not institution 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Country) **Funeral** 212-56-4389 Director 1 - M 2 1 F 62 Yrs July 12, 1949 Maryland Usual Residence of Deced 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director otified 1 Yes 2 No Waldorf <u>Maryland Charles</u> 10e. Street and Number ō 10g. Citizen of What Country? be ms 23a must be 20601 Funeral 6106 Ronna Circle United States items 2 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō à 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: Specify: White "natural" 3 Widowed 4 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Al Hygiene.
Jd other the than College (1/4or 5+) Elementary/Secondary (0-12) Own Home Housewife Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) t of Health and Mental H If item 27 is marked of or other traumatic ever ည Cecelia Joyave Edward Hammon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 Rambling Ridge Ct., Pasadena, Maryland 21122 Lyn Rapolla/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Loudon Park Cemetery Apr.20,2012 Baltimore, Maryland 22. Name and Address of FaciAMBROSE FUNERAL HOME, INC. Signature of Funeral Service Licensee 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ ACUIT MYOCANDIAL disease or condition Medical resulting in death) Examiner ARRYMINA Sequentially list conditions Examine Due to (or as a cor if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UPPHALOPINNY ANUXI C the burial-tran attending physician and or Attending Physician; The law requires that the death certificate be exec Due to (or as a consequence of Physician/Medical Brown P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed 1 Yes 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 9 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director, After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) in mon-UPSHINGTON MCDICAL filed (Month, Day, 32. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 19, 2012 Physician/ 7:10 A. Virginia Anna Bock Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** N/A Baltimore Hamilton Center 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 1 🗆 M 2 🖳 F May 13, 1917 94 Maryland 212-03-9322 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must ha marified at 10b. County 10c. City, Town or Location 10a. State Director 1 🗌 Yes 2 🗓 No Baltimore Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21227 1021 Howland Square USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. White 3 ¥ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tailoring <u>Seamstress</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mary Rudolfo Joseph Perrera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1021 Howland Square Baltimore MD 21227 Sandra Laubenheimer: Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/21/12 Baltimore MD Druid Ridge Cemetery 4 Donation 5 Other (Specify) Entombrent 22 Name and Address of Facility Inc Tuneral Service License 5305 Harford Road Baltimore Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Physician/ seme disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Yes been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ finknown Division of Vital Records, The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? 1 🗌 Yes 2 🗌 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ■ Nursing Home 5 □ Residence 6 □ Other (Specify) မ this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes injury Natural 5 Pending 2 🗌 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig 20

DHMH 17 Rev 7/2009

State Registrar Pakville, MD 21234

e of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sign

Ramana Kankanala, M.D.

31. Date filed (

8813 Waltham Woods Road

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARY SHEILA BOHRMAN APRIL 13.2012 0950 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death BRIGHTVIEW ASST. LIVING HARFORD AIR If Under . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 😿 F Month: Hours Min JUNE", 17 Yel 933 406-42-3881 KENTUCKY 78 **Director** Usual Residence of Decedent 28a-f show 10a. State the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD. HARFORD **JOPPA** 1 Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a 424 LARKSPUR DRIVE 21085 USA "natural", or items 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Completed 3 Divorced 4 Divorced Specify. WHITE 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) DIRECTOR OF CHRISTIAN EDUCATION CHRISTIAN EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental H rtant: If item 27 is marked of ည CLEMENT A. CAMPBELL MARY E. DAVIS traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALBERT BOHRMAN SPOUSE 424 LARKSPUR DRIVE JOPPA, MD. 21085 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of I Important: If its any injury or o' 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) DULANEY VALLEY 4-19-2012 TIMONIUM, MD Signature of Funeral Service Lichnsee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BEL AIR 610 W. MACPHAIL ROAD BEL AIR, MD. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical for as a consequence Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-trans physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for 5 Other (specify) Month Day Year Pregnant at time of death Yes detached 1 ☐ Yes ∠ y 9 ☐ Unknown 9 Unknown is been signed by the should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas director, page 2 performed certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending 24 hours after death Funeral Director: A Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined completed filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one within 2 To the I

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month A0212 FLORENCE BENNETT Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death SINAL HOSPITAL BALTIMORE CITY OF BALLIMONE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 89 Director 220-24-7897 1 🗆 M 2 🖺 F Usual Residence of Deced or 28a-f show Hygiene. other than "natural", or items 23a or 28a-f shov rent, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location Director **Baltimore Baltimore** MD BENNEST the 10e. Street and Number 10f. Zip Code Funeral 21228 2 Union Hall Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No ģ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 FLONENCE If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) LPN 12 and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) when inoun as Robert Williams Sr. injury or other traumatic 19a, Informant's Name/Relationship (Type, Print) Department of Health ar Important; If item 27 is any injury or other trau Julian Bennett altimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State Apr 19, 2012 King Memorial Park 4 Denation 5 Other (Specify) 22. Name and Address of Each Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Signat 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physiciani SHOCK SEPTIE disease or condition Medical resulting in death) **Examiner** SACRAL VICER Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate burial-tra that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as the l ed by the attending detached for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, FAILURE TO THRIVE peen 24a. Was an page 2 autopsy this certificate has performe 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Division of Vital the funeral director, 26. Place of Death (Check only one) Be Hospital 1 🔀 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: work? 1 ☐ Yes 2 ☐ No Natural injury 5 Pending Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined the Hospital Medical 29a. Certifier (Check within 2 only one 29b. Signature

Year 14 04:09 2012 4c. County of Death Birthplace (State or Foreign Country) (Month Clay, 1922 10d. Inside City Limits 1 Tyes 2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black Specify 16b. Kind of Business/Industry Nursing 18. Mother's Name (First, Middle, Maiden Surname, **Eleanor Williams** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Union Hall Court Catonsville, MD 21228 20c. Location - City or Town, State Windsor Mill, Md. Approximate Interval Between Onset and Death 3 DAYS MONTH 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2. No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) RES-000 APRIL 14, 2012 and address of person who completed cause of death (Item 23a) (Type, Print) MBBS SINA HOSCITAL BATTIMONE ASARIT MULTANI 31. Date filed (Month, Day, Year) APR 2 0 2012 32. Registrar's Schature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bronak 825 AM LU/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Director 220-36-5407 72 1**X** M 2 □ F Jan.15, 1940 Baltimore, MDor 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Funeral 21061 USA 16 3rd Avenue South Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, med Forces? Black, White, etc 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify White 3 Divorced 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 72 Elementary/Secondary (0-12) Auto Mechanic Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ၉ Helen Slaski Jöseph Bronakoski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 3rd Avenue South, Glen Burnie, MD 21061 permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Mary Louise Bronakoski - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🏿 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 🗋 Donațion 5 🗀 Other (Specify) cemetery, crematory or other place)
Meadowridge Mem. Park 04/20/2012 Elkridge, Maryland 22. Name and Address of Facility Gary L. Kautman F.H. @ MMT 21. Signature of Funeral Service L M01283 7250 Washington Blvd., Elkridge, Maryland 21075 Part T. Bhter the disease shock, or heart failure. Li 23a. Part 1 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate nly one cause on each line Immediate Cause (Final Onset and Death Ph_sician Moros der It cont disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to for as a consequence of, cause. Enter Underlying Cause (Disease or injury burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Year 9 Unknown 9 Unknown p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director. After this certificate h completely filled in by the funeral director, page performed 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 100 မ 1 Inpatient 2 SER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At hor building, etc. (Specify) At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State Registrar

29b. Signature and tiple of certif

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29c. License numbe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 20c, per fn, g926 4-20-12 sm State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Barksdale 1811 PM Kosa Led 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death NA 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Security Number 8. Date of Birth 6. Sex Hours (Month, Day, Country) 217.05.940 97 Yrs 1 🗆 M 2 🗶 F 1914 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location alley 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 1736C Boulevard USA Player 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 1. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify: Black 3 ₺ Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Rosewood Training College (1-4 or 5+) Elementary/Secondary (0-12) Attendant Schoo) 12th grade year 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) General Purvis Staton Emma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barksdate Alenue Baltimore MD Finney Joseph 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Pikesville,MD mid Ridge Cemeters 04/20 12012 17214 Greene Tuperal services 21. Signature of Funeral Service Licensee Vaugh Vare Koad Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sheet as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final ALZHEIMERS FND disease or condition resulting in death) EMENTIN UNKNOWN Due to (or as a consequence of) Sequentially list conditions, Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FRIERY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 C NO 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury 1 Hatural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🔲 Homicide determined City or Town, State)

Examiner P.O. Box 68760 Division of Vital Records, I or Attend safter death Director: A Hospital

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Medical Certificate:

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29b. Signature

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Baltimore, Maryland 21215-0036

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other traumatic event,

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within 24 hours 6 gm

CEDRK DARY 900 31. Date filed (Month, Day, Year) 2012

SOUTH CATON 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D 70718

29d. Date signed (Month, Day, Year)

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MD

2012

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APRIL

BALTIMORE

29c. License number

AVINUE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ VIRGINIA **IRENE** BRUCE APRIL 1:01P M 16,2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) **Director** 229-76-5697 62 1 □ M **XX** F 12/28/1949 Virginia ms 23a or 28a-f show must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2XXNo Maryland Hunt Valley 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 735 Weil Mandel Wav 21030 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Examiner 14. Race - American Indian, Armed Forces?

1 Yes 2 XXNo or Black, White, etc. þ XX Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. If Yes, Give "natural" Completed 3 Widowed 4 Divorced Specify White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Art Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Rawlings Edward Bruce Dorothy Irene Gibbs 19a. Informant's Name/Relationship (Type, Print) and is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Cordelia Bruce Sister 735 Weil Mandel Way Hunt Valley Maryland 21030 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Page 1 ō cemetery, crematory or other place) permit. Page Department of Important: If any injury or once, Greenwood Cemeterv 04/20/2012 Donation 5 Other (Specify) Bedford, Virginia 22. Name and Address of FagWitchell-Wiedefeld Funeral Home Inc ignature of Funeral 8 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY ARREST Physician/ Medical Due to (or as a consequence of): Examiner DIABETES MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of MASSIVE OBESITY Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical requires that the death certificate be Box 68760 ası attending IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No Year 1 Yes 2 L 9 Unknown Pregnant at time of death P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performed? Yes 2 X No pade or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ပ 1 Inpatient 2 KER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 XNatural 5 - Pending work? e Funeral Director: Al sletely filled in by the fu Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature a 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Yea APR 2 0 2012 DHMH 17 Rev 06-2011

30. Name and address of person who co

TIMOTHY BESSENT, M.D.

pleted cause of death (Item 23a) (Type, Print

20015452

7601 OSLER DRIVE TOWSON, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year Physician/ RTER RTHUR Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore VA Nursing Home Loch Raven 8. Date of Birth (Month, Day, Year) 03 07 29 if Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. VA 230-34-3580 Director 83 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County **Funeral Director** Examiner must be notified 28a-f 1 X Yes 2 No Baltimore NA MD 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Number 23a U.S.A. 21216 1629 North Dukeland Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after death 12 Was Decedent Ever in U.S. 14. Race - American Indian, med Forces? Black, White, etc. þ "natural", or 1 Never Married 2 Married Y Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 💢 No Specify: Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) General Motors Manufacturer 10th grade permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Thelma Lawson McKinley Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Balimore, Md 21216 North Dukeland St., Blanche Carter-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Vet 4/25/2012 Owings Mills, 4 Donation 5 Other (Specify) Garrison Forest 22. Name and Address of Facility March F/H West 4300 Wabash Av Signature of Funeral Service Licensee Baltimore, Md Ave 23a. Par 1. Enter the disease, or complications that cause 1 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shrick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im Tediate Cause (Final Physician/ ANC disease or condition Medical resulting in death) Due to (or sea onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Other (specify) Pregnant at time of death Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury work? 1 Yes 1 Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check only one) 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEBKIT 31. Date filed (Month, Day, Year) 200 2012 32. Registr 's Sign State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 100 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 57<u>15 Park Heights</u> imore If I Inder 24 Hrs. Ave 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under **Funeral Director** 220-86-8116 1 M 2 XF 38 03 18 74 MD Usual Residence of Decedent 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1X Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5715 Park Heights Ave 21215 U.S.A "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married Yes Yes, Give 2 **N**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Oth grade Unemployed na **Unemployed** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked any injury or other traumatic eve မ Leonard Torrence Renarta Spence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawnette Torrence-Daughter Park Heights Ave, Baltimore, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Trinity 4/26/2012 Baltimore, Md of Funeral Service License 22. Name and Address of Facility March F/H West 4300 Wabash Av Baltimore, 23a. Part 1. Enter the disease, or complications that caus d shock, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death nomediate Cause (Final Playsician/ ance K disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 🗷 No 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) မ 1 🗌 Inpatient 2 🗍 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending work hours after death. 1 Yes 2 🗌 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State Registrar 30. Name and address of person who

31. Date filed (Month, Day, Year)

npleted cause of death (Item 23a) (Type, Print)

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Physicia Medi Exami **Funeral Director** Department of Health and Mental Hygiene. Important: If items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Audrey in Baltimore, Maryland 21215-0036 CZarski Physician/ Medical Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 (To the Hospital or Attending Physician: The law requires that the death certificate be executed

	Please T	ype or Print State of Mary						ble.		
	1 - For State Registrar	State of Iviary		tificate of L				112 12343		
an/	Decedent's Name (First, Middle, Last) Audrey	М.	Cza	rski		2. Date of Dea		Year 1/27 P M		
cal ner	4a. Facility Name (if not institution, give str		7.1		Location of Death	1	4c. County of			
	FRANKLIN SQUAR 5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird	th	9. Birthplace (State or Foreign Country)		
	Usual Residence of Decedent	M 2 X F	76 Yrs.			Septembe	r 13,1935	Maryland		
rector	10a. State 10b. County Maryland N/A	10	oc. City, Town or Lo Baltim					10d. Inside City Limits 1 ※ Yes 2 □ No		
eral Di	10e. Street and Number 4516 Shamrock Avenu	ie		10f. Zip Code	21206		10g. Citizen of W USA	hat Country?		
d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.	1	Was Decedent of H f Yes, specify Cuba	n, Mexican, Puerto	pecify Yes or No- Rican, etc.)		- American Indian, s, White, etc. White		
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To Be	17. Father's Name (First, Middle, Last) John Sturgeon			acorer		ne (First, Middle,	Maiden Surname)	·· -		
	19a. Informant's Name/Relationship (Type Margaret Lemke	e, Print) Daughter		ng Address (Street Eastern						
•	20a. Method of Disposition 1 ☐ Burial 2 【***Cremation 3 ☐ Re		20b. Place of Dispo		e) Apri	Pate17,	20c. Location - 0	City or Town, State		
	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen Le	ļ.	Bayview C		201			re, Maryland		
	John Call							P.A. Md. 21222		
	23a. Part 1 Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.		-	-	or respiratory ar	rest,	Approximate Interval Between Onset and Death		
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ш	that initiated events cresulting in death) Last	Due to (or as a co	Due to (or as a consequence of):							
/Med	IF FEMALE: 23b. Was decedent pregnant 23	Bc. If <u>ye</u> s, outcome of p	pregnancy				22d Date	e of delivery		
Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live Birth 2 4 Pregnant at tim		_ Ectopic pregnand Other (specify)	cy		Mon			
I by PI	Part II. Other significant conditions cont	ributing to death but n	not resulting in the L	inderlying cause gi	ven in Part I.			bute to the cause of death? 3 Probably 4 Onknown		
Completed by						24a. Was	an 24b. W	/ere autopsy findings available rior to completion of cause of		
	25. Was case referred to medical			26 P	ace of Death (Che	1 Tyes		eath? Yes 2 No		
To Be	1 L Yes 2 No		2 ER/Outpatie	nt 3 🗆 DOA Oth	er: 4 Nursing F	lome 5 🗆 Resid	dence 6 Other			
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Medical Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	- At home, farm, str Specify)	eet, factory, office		28f. Location (\$ City or Tox		r or Rural Route Number,		
Medica			nination and/or inves	tigation, in my opini	on, death occurred	at the time, date a	and place, and due	to the cause(s) and manner stated.		
-	29b. Signature and title of certifier	- M.	O.	29c. Licens	63289		29d. Date signed	(Month, Day, Year)		
	30. Name and address of person who com	npleted cause of death	n (Item 23a) (Type, I	Print) FRANKLO	n Spac	ire DR		nd 21237		
ite ar	31. Pap Red (Month 2012 ar)	32. Regultrar's	Jan J							

DHMH 17 Rev 06-2011

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ronald Keith Counsell Day April 17, 2012^{eat} 6:02 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Gilchrist Hospice Center Baltimore County Towson Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Days Hours Min 516-48-2735 70 **Director** 1 X M 2 □ F Sept. 05, 1941 Kalispell, Montana 28a-f shov 10a. State at the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No Maryland N/A Baltimore 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe: Funeral 23a Fallsbridge Drive 4413 K 21211 United States must items / Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status marked other than "natural", or iten matic event, the Medical Examiner 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 X No 21215-0036 1 ☐ Yes 2X No Specify White 3 Widowed 4 Divorced Specify: Completed Year or Dates. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) College (1--(Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) (1-4 or 5+) Chemist U.S. Filter Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clinton Counsell Ethel Elizabeth Thorpe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr.Keith Mansfield Counsell(Son) 1101 St.Paul Street #1210 Baltimore, Maryland 21202 item 2 20b. Place of Disposition (Name of permit. Page 1
Department of Important: If it any injury or o (Harford County) 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Evans fure all Oracel and Cremation Services, Inc. Sunday, 4 Donation 5 Other (Specify) April 22, 2012 Forest Hill, Maryland of Funeral Service License Jeffrey L.Cair, Sr. CFSP 22 Name and Address of Facilities Funeral and Cremation Center, P.A. . Signature dr. 4. Lic. #100677 2325 York Road Timonium, Maryland 21093-2215 t 1. Duer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) le to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events and burial-tra Due to (or as a consequence of). resulting in death) Last the attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 as the l IF FEMALE: use ves, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) Yes 2 No detached g Unknown 9 Unknown been signed the should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Ves 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Was an autopsy performed? 24a. Was an cate has l this certificate To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 4 Nursing Home 5 Residence 6X Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of De th 28a, Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated | Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year APR 2 0 2012

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death	ath certifica attending p or use as th	sician/)	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 [4 Pregnant at time of 5 [ancy Month	Day Year
25. Was case referred to medical examiner? 1	that the dended by the detached for		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		
25. Was case referred to medical examiner? 1	law requires has been sig 2 should be	npleted	Stabetoe internace		autopsy prior t	o completion of cause of
1 Yes 2 No No Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, or Town, State) 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Yea	: The ificate r, page	ပ	25. Was area referred to medical	26 Place of Death (Check		Yes 2 No
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29c. Croense number O.C.M.E. April 8, 2012	pital or Ati ours after di eral Direct filled in by	ertifi	3 Suicide 6 Could not be determined (Specify)	m, street, factory, office building, etc.		Rural Route Number, City
29c. License number O.C.M.E. April 8, 2012	To the Hos within 24 h To the Fun completely		(Check only one) 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	vestigation, in my opinion, death occurred a	at the time, date and place, and due to	the cause(s)
		×	(Latolewy)			vionth, Day, Year)
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature			Laron Locke MD. Assistant Medical Examiner 900	W. Baltimore Street, Baltimore,	MD 21223	

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 17, 2012 3:07 A M Chao Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10841 Tuckahoe Way Montgomery Gaithersburg Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Aug 27, Months Days Hours Min Director 1 🗆 M 2 💢 Taïwan 616-74-0173 38 Vrs 28a-f show ral", or items 23a or 28a-f shore Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20878 USA 10841 Tuckahoe Way within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. "natural", Completed 3 Widowed 4 Divorced Year or Dates Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Information Technology Computer Programmer Be 18. Mother's Name (First, Middle, Maiden Surname) Shi-Feng Ko 17. Father's Name (First, Middle, Last) Chi-Sheng Chao 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a If item 27 is 10841 Tuckahoe Way Gaithersburg, MD 20878 Ting-Chung Hu/husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 04/21/12 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the tisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 9 years Physician/ Fibrolamellar Hepatocellular Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 the 33 attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 Month Pregnant at time of death 5 Other (specify) Day Year Yes 2 X No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an or Attending Physician: The law has autopsy performed? page 2 certificate Yes 2 No funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 🔀 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred e Hospira. ... n 24 hours after death. ... he Funeral Director: After a Funeral Director After a Funeral Director After a Funeral Director After a Funeral Director After a Funeral Director After a Funeral Director After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After After Af 1 X Natural 5 Pending injury Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defining Prinstrain. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\(\sum_{\text{State}} \)

To the within 2 To the Comple

29b. Signature and title of certific

APR 2 0 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

George Sotos, M.D. 9707 Medical Center Dr. #300 Rockville, MD 20850

32. Reastrar's

29c. License number

D43083

29d. Date signed (Month, Day, Year)

April 17, 2012

			For State Registrar		State of M	larylan	-	rtment of F tificate of i			/giene Reg. No	7111	2 1234
				ne (First, Middle, Las	st)					2. Date of De	eath Da	ıy Year	3. Time of Death
	Physicia Medic		Barba	ra Virgini	a Clemen	ts				April	9	, 2012	2:50 p ^M
	Examin		4a. Facility Name	(If not institution, give	e street and numbe	r)		•	r Location of Death	h		. County of Death	
			Holy Cro	oss Hospit		ige (In vre)	last birthday)	Silver	Spring If Under 24 Hrs.	8. Date of Bi	rth	ontgomer 9. Birth	place (State or Foreign
	uneral irector		263-72-8	_ 1	□ M 282MF	7.3	V-0	Months Days	Hours Min.	May 19	ay, Year)	Cot	GA
р			Usual Residence	of Decedent									10d. Inside City Limits
arylan	show	-	10a. State	10b. County			y, Town or Lo	cation					1 □Yes 2xxXNo
he M	58a-f	Director	MD	Prince Ge	eorge	Lauı	rel.	10f. Zip Code			10a Ci	tizen of What Cou	
with t	a or		10e. Street and No					20707				SA	,
death	ms 23	Funeral	11. Marital Status	Jerald Roa	12. Was Deceden		S. 13. \	Vas Decedent of H	lispanic Origin? (S	Specify Yes or N		14. Race - Amer	
d 616.13-0000 filed within 72 hours after death with the Maryland Hydione	Department or result and wenter rayeries. Department or result and wenter rayeries are seen than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mactical Eventings must be resulting at once.	by Fur	1 Never Mar	rried 2 🔀 Married	Armed Forces 1 □Yes 2 If Yes, Give Year or Dates	X No		fYes, specify Cuba I∐Yes 2∑xNo	Specify:	to Hican, etc.)		Black, White Specify: Afi	
n 72 hou	"natura edical E	Completed		15. Decedent's Ed	ide completed)		I (Give	dent's Usual Occup kind of work done OO NOT use retire	durina most of wo	rking	16b. k	Kind of Business/I	
within	than	mo	Elementary/Sec	condary (0-12)	College (1-4o	r 5+)	Teacl		,		Edu	cation	
peliled Hwe	other other	Be C	17. Father's Name	First, Middle, Last,					18. Mother's Nar	me (First, Middle	e, Maidei	n Surname)	
uld be	arked atic e	2	Rober	t Vernon	Simmons		- Y		Lucy S				
2 sho	Is II			Name/Relationship (a	1	ng Address (Street					?ip Code)
and	m 27			Clements	, II / :	Son		9 Jerald		Date Date		ocation - City or	Town, State
ges 1	or of			2 ☐ Cremation 3 ☐		e		sition (Name of natory or other pla	! -	il 20,			
it. Pe	ortant injury	1.8		5 □ Other (Specil Funeral Service Licer		Mea	dowrid	ge Mem.P		2012 onaldson		rsey, M <u>D</u> neral Hor	
per D	Impor any ir	1 8	DQ. Ke	inSlile		1053		313 Talbo					
			23a, Part 1. Enter	r the disease, or comeant failure. List only	plications that caus	ed the deat	h. Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between
Phy	sician		Immediate Cause	e (Final	_a Acute R		atory	Failure					Onset and Death
	ledical aminer		resulting in death			as a conseq							
LAC	allillet	-	Sequentially list o	conditions,	b. Chronic	Puli		Fibrosis	5				
ted	nsit	Examiner	cause. Enter Und Cause (Disease of that initiated even	derlying or injury	Due to (or t	zo a outrocy	acrice ory.						
execu	n and ial-tra	Exa	that initiated ever resulting in death	nts) Last	C. Due to (or a	as a conseq	uence of):						
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rtifical	ng ph as th	Medi	IF FEMALE:		0	.nt		- 12	- W-				
OI VICAL DECOLOS, T.O. DOX 00100, Physician: The law requires that the death certificate be executed	the attending poshed for use as t	ysician/M	23b. Was decede in the past 1 1 □ Yes 2 9 □ Unknow	12 months? 2 XX No	23c. If yes, outcon 1 Live birth 4 Pregnan 9 Unknown	n 2 ☐ Feta tat time of o	al death 3[☐ Ectopic pregnand ☐ Other (specify) _	су			23d. Date of de Month	ivery Day Year
that	signed by the a d be detached f	y Phy	Part II. Other sign	nificant conditions	contributing to death	but not res	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
Olds, requires t	an sig uld be	ed by								1 🗆	Yes :	2 □ No 3 □ P	robably 45 Unknown
he law re	e has been s ige 2 should	Completed								_ per	opsy formed?	prior to death?	utopsy findings available completion of cause of
a :	rtifical tor, pë	0	25. Was case ref	erred to medical					26. Place of De	1 □Yes eath (Check only		10 10 10	ZENO
ysici	nis ce direc	10 B	examiner? 1 ☐ Yes 2,	No	Hospital: 1 🔀 Inpa	atient 2] ER/Outpatie	nt 3□DOA Ot	her: 4 🗆 Nursing	Home 5 ☐ Re	sidence	6 ☐ Other (Spe	ecify)
= E	n. After this certificate ha funeral director, page	.: E	27. Manner of De 1XXNatural	ath 5 Pending	28a. Date of I (Month,	njury <i>Day, Year)</i>	28b. Time o Injury	Wo		28d. Describe	e how inj	ury occurred	
SIOI Itending	rector: Are full by the full	cati	2 ☐ Accident 3 ☐ Suicide	investigation 6 □ Could not be	0	Injury . At h	ome farm et	M 1 C reet, factory, office]Yes 2□No	28f Location	(Street	and Number or R	ural Route Number,
or A	Direct Direct I in by	Certification:	4 🗌 Homicide	determined	building,	etc. (Speci	fy)	eer, lactory, onice		City or T	own, Sta	ite)	,
To the Hospital or Attending	within 24 hours in To the Funeral I completely filled	Medical C	29a. Certifier (Check only one)	XXCertifying P 2☐ Medical Exa	hysician: To the be miner: On the basi and manner	s of examina	owledge, dea ation and/or i	th occurred at the ovestigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the tim	he cause e, date a	(s) and manner a and place, and due	s stated. e to the cause(s)
o the	omple	Med	29b. Signature ar	nd title of certifier	and mariner	otatod.		29c. Licen	se number		29d. D	Date signed (Mon	th, Day, Year)
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	01			idress of person who									
	1			Khan, MD,				d, Silve	r Spring	, MD 20	910		
	Sta Regist	ate rar	31. Date filed (M	onth, Day, Year) PR 2 0 2012	beer Hegi	istrar's Signa	Lan	20					

obert Cassell		State of Maryland / Department of Health and M 1-For State Registrar Certificate of Death	/lental l		Reg. No. 21	012 1234	
Physicia ledical Exami		Decedent's Name (First, Middle,Last)		2. Date of De Month April 15,	eath Day Year	3. Time of Death	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Local 105 Windy Falls Way, #F Cockeysville	ation of Dea		4c. County of Baltimore		
Funeral Director			Under 24H Hours M		Birth(MM/DD/YYYY) 9/1949	9. Birthplace (State or Foreign PA	
and show any	ī	Usual Residence of Decedent 10a. State 10b. County MD Baltimore 10c. City, Town or Location Cockeysville				10d. Inside City Limits 1 Yes 2 X No	
with the Maryland ms 23a or 28a-f sho be notified at once	Director	10e. Street and Number 105 Windy Falls Way, #F 21030			10g. Citizen of Wha	at Country?	
after death	by Funeral	3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Specify:					
1215-0036 d be filed within 72 hours fental Hygiene. rarked other than "natur event, the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 16a. Decedent's Usual Occupation (0 during most of working life. DO I Administrator TRS	NOT use re	etired)		overnment	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: Witem 27 is marked other than injury or other traumatic event, the Medica	To Be Co		orothy	E. Sch		State Zin Code\	
and 2 shou cealth and ? tem 27 is straumatic	-	Lance Cassell / Son 5227 Sweet Air F	Rd., E		, MD 21013		
Baltimore, permit. Pages I a Department of He important: If ite	9	1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Removal from State W. Arundel Crematory 22. Name and Address of Fa	-		2 Odenton,		
Balti Balti Departm Importa		21. Signature of Funeral Service Licensee M01452 22. Name and Address of Fa Bailey Funera 4023 Annapoli 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such	<u>ıs ka, </u>	, натет	norpe, M	J ZIZZI	
: Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Due to (or as a consequence of):	Disea	se		Between Onset and Death	
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
outed ransit	I Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.					
'60, ate be exe	Medical	■ X UNPENDED	.2 sm		23d. Date of d	delivery	
Box 6876(e death certificate the attending physed for use as the b	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ecc 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	ctopic pregr	nancy	Month	Day Year	
r, P.O. I	ğ	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in	in Part I.			oute to the cause of death? Probably 4 Unknown	
Division of Vital Records, P.O. Box 6876(To the Hospital or Atteoding Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the b	Completed			pen 1 ✓ Yes	opsy pri formed? de	ere autopsy findings available for to completion of cause of sath? Yes 2 No	
of Vital ing Physician: After this certil uneral director	To Be	25. Was case referred to medical examiner? 1 V Yes 2 No	er ₄ Nurs	ing Home 5	Residence 6	-	
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Division To the Hospital or Atteod within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier (Check only one) 29a. Certifor 29a. Certifor 29a. Certifor 31 Certifor 31 Certifor 31 Certifor 31 Certifor 31 Certifor 32 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deat					
(b)	Me	29b. Signature and title of certifier O.C.M.E.			29d. Date signed April 16, 201	d <i>(Month, Day</i> , Year)	
Oxpend		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimor	re, MD 2	1223			
Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 18, per fh, g927 5-3-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month c Physician/ Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Season's Hospice Randallstown Baltimore . Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Pay, Year) 04/13/1942 **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Maryland 1 M 2 D F 220-76-3290 **Director** 70 Yrs Usual Residence of Deceden 28a-f show the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director an "natural", or items 23a or 28a-f sl Medical Examiner must be notified MD Baltimore 1 Yes 2 No Milford Mill 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 2424 Bibury Lane 21244 USA and 2 should be filed within 72 hours after death 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 X Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify: Year or Dates Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the 0 Did Not Work N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ပ Jennie Goon Whence Chen 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai Dennis Chen / Brother 2738 Thornbrook Road, Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 4/20/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Borota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ ney Medical Examiner Sequentially list conditions if a y, Labing to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical P.O. Box 68760 as IF FEMALE: for use yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregna☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe Division of Vital Records, page 2 should Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law After this certificate has autopsy performed? Yes 2 N 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **N**No 1 🗌 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural death. within 24 hours after death

To the Funeral Director: A

completely filled in by the in Accident Investigation 2 🗌 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific License numbe

DHMH 17 Rev 06-2011

State Registrar 30. Name

and address of pe

31. Date filed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 04 Day 14 Richard Wayne Cullison, Sr. 2012 9:22 AMMedical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 100 N. Broadview Blvd Glen Burnie Anne Arundel Social Security Number If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Days Min. Maryland 02/09/1946 X 1 □ M 2 □ F 214-44-6723 **Director** 66 Yrs Usual Residence of Decedent 28a-f show 10a, State 10d. Inside City Limits the Maryland notified at 10c. City, Town or Location Director 1X Yes 2 □ No MD Anne Arundel Glen Burnie 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe I ms 23a o Funeral 100 N. Broadview Blvd 21261 **USA** items ? Page 1 and 2 should be filed within 72 hours after death viment of health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items urry or other traumatic event, the Medical Examiner murry or other traumatic event, the Medical Examiner murry or other traumatic event, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates Specify Completed 3 X Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Truck Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Leon Cullison Caroline McKay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacey L. Fracalossi / Daughter 906 Patridge Berry Lane, Chestnut Hill, MD 21226 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 4/18/2012 Beltsville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician | physem disease or condition m Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Hupentensi within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State

Registrar DHMH 17 Rev 06-2011 only one

31. Date filed (Month, Day, Year)

APR 20

cause of death (Item 23a) (Type, Print

32. Registrar's

29c. License number

29d. Date signed (Month, Day, Year,

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David	Reed	Cros

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	Physici I Exami		Decedent's Name (First, Middle, I David Reed Cro	•					2. Date of Dea Month April 13, 2	Day	Year	3. Time of Death 1100 hrs
)			4a. Facility Name (if not institution,	give street and number)			4b. City, Town, or L	ocation of Death			County of Deati	1
,			7400 Lakeview Drive Ap		- 74		Bethesda				ontgomery	
	uneral			Sex 7. Ag	e (In yrs. 84	last birthday) Yrs	Months Days	If Under 24Hrs Hours Min.			Foreig	thplace (State or on Shington , D.C.
	ńa n		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Locat	ion					10d. Inside City Limits
	d bow a	L	Maryland Montgo	merv		,		hesda				1 Yes 2 X No
	Sa-fs	Director	10e. Street and Number	mery			10f. Zip Code	певаа	11	10g. Citize	en of What Cou	ntry?
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21;	d Men s mar tic eve	To E	19a. Informant's Name/Relationship			19b. Mailing	Address (Street			mber, City	or Town, State	, Zip Code)
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Baltimore,	of He		1 X Burial 2 Cremation	3 Removal from Sta	ate	crematory or oth	ner place)	Ap	Date ril 20,		ocation - City or	·
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			Sequentially list conditions,	b.	equence o	т):						
	4	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence o	rf):						
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ox 6	attend or use	Physician/	1 Yes 2 No 9 Unkno	Wn 0 University	time of de	ath	ner (Specify)			•		
Ö.	by the	Phy	Part II. Other significant condition	9 Unknown	but not n	esulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	obacco us	se contribute to	the cause of death?
Δ.	signed by	d by	Hypertensive Atheroscl	erotic Cardiovascı	ılar Dis	ease			1Ye	s 2 🗸	No 3 Prob	ably 4 Unknown
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1	within 24 hours after death. To the Funeral Director: completely filled in by the 1	edical										
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\mathcal{L}	1 8	n		30. Name and address of person who completed cause of death (tem 23a) /Fine Prior)	+	Apr	1/2	7	2/2
State State Registrar 32. Registrar's Signature Registrar	2	,		ΔI^{*}	Julioto	un,	mes	4/2m	d
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month 4 George Mitchell Correll 2013 0424A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicanico Recional Salisbur medical center **Funeral** If Under 1 Year If Under 24 H/s Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Min. 222-36-0132 **Director** 1 🛛 M 2 🗆 F 53 01/01/1959 Delaware 28a-f show the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 □ No Sussex Millsboro 10e, Street and Number ō 10f. Zip Code r items 23a or iner must be n 10g. Citizen of What Country? Funeral 31533 Careys Drive U.S.A. 19966 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. th and Mental Hygiene. 27 is marked other than "natural", or itel traumatic event, the Medical Examiner 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Meat Inspector Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jacob Alvin Correll, Jr. Virginia Lee Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a David Z. Correll / Brother 230 Emma Way, Newark, DE 19702 20a. Method of Disposition Department of H Important: If ite any injury or oth 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 04/17/2012 Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ Medical resulting in death) Due o (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last ig physician and as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregna ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Pregnant at time of death Month Day signed by the ar 1 Yes 2 L 9 Unknown 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Nes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has I autopsy Hospital or Attending Physician: The Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 🗌 Yes 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? Accident Investigation Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral E

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 L Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 32. Registrar's Signatur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 12:00P M RONA COHEN APRIL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE NORTH OAKS HEALTH CENTER PIKESVILLE Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 213-20-3899 Director 1 🗆 M 2 🗓 F 87 01/02/1925 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 X No BALTIMORE MD OWINGS MILLS 0 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be Funeral 20 PINEWOOD FARM COURT 21117 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify Specify: 3 Widowed 4 X Divorced Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the HOMEMAKER OWN HOME event. Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o Department of Health and Menta Important: If item 27 is marked any injury or other traumatin conce. ပ LEOPOLD WOLF GILDEN IDA LANDSMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RANDI SOPHER/DAUGHTER 20 PINEWOOD FARM COURT, OWINGS MILLS, MD 21117 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 04/19/2012 Donation 5 Other (Specify) REISTERSTOWN, MD BALTIMORE HEBREW re of Funeral Serv 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD. PIKESVILLE, MD 21208 . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ week disease or condition Medical resulting in death) Due to (or as Examiner 18avs Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence burial-transi Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as the 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ည 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)

Division of Vital

After this certificate has e Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certific funeral completely filled in by the

within 2

29a. Certifier (Check only one

Certificate:

27. Manner of Death

Natural

4 Homicide

Accident

1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

2 0 2012

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2835

037513

2 🗆 No

28c. Injury at

work?

29d. Date signed (Month, Day, Year,

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Mo

18,2012

2/209

30. Name and address of person who cause of death (Item 23a) (Type, Print) 2, bel

5 Pending

Investigation

determined

6 Could not be

Registrar's Signature

28a. Date of injury (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ onth _ 830A M RISGILL Medical 4a. Facility Name (if not institution, give street and number) **Examiner** County of Death Baltimore Catonsville Charlestown Community Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Months Days Hours Country Director 1X M 2 □ F 215-18-0829 88 Aug. 16,1923 Maryland or 28a-f show notified at 10c. City, Town or Location with the Maryland 10d. Inside City Limits Funeral Director 1 🗌 Yes 2 🔀 No Catonsville Baltimore items 23a or ner must be n 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane, Apt.CC419 USA 21228 permit. Page 1 and 2 should be filed within 72 hours after death v bepartment of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1943-12 Yes $2 \square No 1946$ If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Railroad Electrician \mathbf{B} e 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Julius Drisgill Susan Reese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Walker / daughter 809 Iron Rail Court Woodbine, Maryland 21797 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 04/18/2012 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service License Stephanie Custer 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Phylician -4NG disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician a d be detached for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicis completely filled in by the funeral director mans 2 should be accompletely filled in by the funeral director mans 2 should be accompletely filled in by the funeral director mans 2 should be accompletely filled in by the funeral director mans 2 should be accompletely filled in by the funeral director mans 2 should be accompletely filled in by the funeral director mans 2 should be accompletely filled in by the funeral director mans 2 should be accompletely filled in by the funeral director mans 2 should be accompletely filled in by the funeral director mans 2 should be accompletely filled in by the funeral director mans 2 should be accompletely filled in by the funeral director mans 2 should be accompletely filled in by the funeral director mans 2 should be accompletely filled in by the funeral director mans 2 should be accompletely filled in by the funeral director mans 2 should be accompletely filled in by the funeral director mans 2 should be accompletely filled in by the funeral director mans 2 should be accompletely filled in by the funeral director mans 2 should be accompletely filled in by the funeral director mans 2 should be accompletely filled in by the funeral director mans 2 should be accompletely filled in by the funeral director mans 2 should be accompletely filled in by the funeral director mans 3 should be accompletely filled in by the funeral director mans 3 should be accompletely filled in by the funeral director mans 3 should be accompletely filled in by the funeral director mans 3 should be accompletely filled in by the funeral director mans 3 should be accompletely filled in by the funeral director mans 3 should be accompletely filled in by the funeral director mans 3 should be accompletely filled in by the funeral director mans 3 should be accompletely filled in by the funeral director man Division of Vital Records, P.O. Box 68760 IF FEMALE: outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Year 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Matural (Month, Day, Year) 5 Pending 1 \square Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11:20 AM Dunphy 2012 Medical Marie POCI 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Anne Arunde more washington Medical Cente 9. Birthplace (State or Foreign Country) Maryland 6. Sex 8. Date of Birth Age (In yrs. last birthday) If Under 24 Hrs **Funeral** (Month, Day, Year) ay 31, 1927 Months Mir **Director** 1 🗆 M 2 🔀 F 84 28a-f show Pasadena notified at _ocation 10d. Inside City Limits Director Anne Arundel Maryland 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be r Funeral 21122 1214 Overview Drive USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀No Specify: white Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Dunphy, Moril 10th Household Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Frank C Joran Schultz injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trae Kathleen Μ Trevino daughter 1214 Overview Dr. Pasadena MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Qonation 5 ☐ Other (Specify) Cedar Hill Cemetery 4/27/2012 Glen Burnie Maryland 21. Signat Stallings Funeral Home P.A. 3111 Mountain Pasadena MD 21122 s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Part 1. Enter the disease, or shock, or heart failure. List or 23a. Part 1 nterval Between Immediate Cause (Final disease or condition Onset and Death -Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 ponths? 5 Other (specify) Month Dav Year Pregnant at time of death been signed by the sahould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law page 2 has autopc, performed? 24 hours after death. Funeral Director: After this certificate 2 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 1) Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at Natural 5 Pending work? Accident Investigation 2 🗌 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

within 2 To the I

(Check

only one) 29b. Signat

31. Date filed (Month, Day,

Year

Name and address of person who completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

Registrar

DHMH 17 Rev 06-2011

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 12357 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day <u>2</u>01̈́2̈́ Virginia Lillian Day April 12 1:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Holy Cross Hospital Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 085-40-7893 Director 1 □ M 2 🌣 F 86 May 8, 1925 Massachusetts 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State must be notified at Director Silver Spring MD Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 USA 23a Completed by Funeral 20904 3144 Gracefield Road #218 ral", or items 2 Examiner mus Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2X No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White "natural", 3 X Widowed 4 ☐ Divorced Year or Dates ed other than "nature event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Mental Hygiene. Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental F item 27 is marked of r other traumatic evel ဂ္ Lillian Stowell Clarence Baxter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4533 South Chelsea Lane Bethesda, MD 20814 Mary Ann Toomey / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/17/12 Woodbine, MD inal Journey Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Going Homes Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre-Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Subdural Hematoma Medical Due to (or as a consequence of): 3 **Examiner** Fall Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury for use as the burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death been signed by the a should be detached 1 L Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes \(2 \sum \) No 24a. Was an page 2 autopsy perform penomed? Yes 2∑ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? 1X Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 🕱 No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending s after death. Apr.8,2012 fell down onto floor unknown M Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Norther or Bural South Number, City or Town, State) Spring, MD determined 3144Gracefield Rd #218 Home 24 hours Funeral Medical 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier

KORZAN GRACEFIELD RD 32. Registrar's Signature

3110

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D57284

29d. Date signed (Month, Day, Year)

SILVER SPRING MARYLAND 20904

APR 12 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Elise H. Davis 2012 8:15 PM April 17, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Oak Crest Care Center Parkville 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2 🖼 F 212-48-3963 June 13, 1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 1 ☐ Yes 2 ☐ No Maryland Baltimore Parkville Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 8832 Walther Boulevard 21234 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Eve Armed Forces? 1 □Yes 2™No If Yes, Give Year or Dates: Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amy Scheidt Herman Henneberger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Silverwood Circle Apt. 3 Annapolis, MD 21043 Anne D. Hicks/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2x Cremation 3 ☐ Removal from State Hilltop Service Corp. 4/19/2012 4 ☐ Donation 5 ☐ Other (Specify) Towson Maryland 21. Signature of Full erat-Service Licenses Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) pneumonia Due to (or s a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery mant 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 X No 1 ☐ Yes

Physician /Medical Examiner

the burial-transi

physician

been signed by the attending p should be detached for use as

page 2 s

certificate

this

To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director.

or Attending Physiclan:

Completed by Physician/Medical Examiner

Be

Certification: To

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permit. Pages 1
Department of H
Important: If ite
any Injury or ot
others

Physician

/Medical

Examiner

Funeral Director

Be Completed by

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hyglene.
snit: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatte event, I'm Medical Evanning in usat tennalined as uny or other traumatte event, I'm Medical Evanning.

5-0036

Baltimore, Maryland

D

P.O. Box 68760,

of Vital Records,

Division

The law requires that the death certificate be executed

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Usease or injury that initiated events resulting in death) Last

IF FEMALE:	
23b. Was dece	edent preg
in the pas	st 12 moni

1 ☐ Yes 2 No 9 Unknown

art II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part
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as case aminer?	referred	to	medi	ca

1 Yes 2 No

Hospital:	1 Inpatient	2 🗆	ER/O	utp
28a.	Date of Injury (Month, Day, Y	ear)	28b.	Tii Inj

Other: 4 Nursing Home 5 🗆 R patient 3 DOA 28c. Inju

26. Place of Dea			
r: 4 Nursing H	ome	5 Residence	6 ☐ Other (Specify)
		Describe how inju	

27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide

4 Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

me of ury

ıry at rk?		28d.	Describe	how	injury	(
Yes 2	□No					

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check or
one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier mone

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Monias 31. Date filed (Month, Day, Year) APR 20

8500

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Month April Physician/ ΑМ 8:58 16 Audrey Elsie Dustin Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Howard Columbia Gilchrist Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number **Funeral** Days Hours Min (Month, Day, Year) Months Director 578-36-8178 1 □ M 2 🗓 F Oct 12, 1928 Maryland 83 Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State must be notified at Director 1 Yes 2X No 28a-f MD Prince George Laurel 10f. Zip Code 5 10e, Street and Number 10g. Citizen of What Country? 23a Funeral 8510 Mulberry Street 20707 U.S.A. death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status ural", or iten If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White Completed 3 ▼ Widowed 4 □ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) School Bus Driver Transportation Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျှ Vernon E. Duval Maude D. Musgrove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melva Futrell /daughter 8510 Mulberry Street, Laurel, Maryland 20707 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Apr 20, 12 4 Donation 5 Other (Specify) Union Cemetery Burtonsville, MD 22. Name and Address of Facility Donaldson Funeral Home, 313 Talbott Ave. Laurel 21. Sign of Funeral Service Licer P.A. Maryland 20707-4389 M00773 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart inclure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Se Ph sician/ DS IS leeke Medical resulting in death) Due to (or as a consequence of): Examiner forateo 01 Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Periphera The law requires that the death certificate be executed and the burial-tra resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the at be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy page 2 certificate Yes 25. Was case referred to medical To the Hospital or Attending Physician: director. 26. Place of Death (Check only one) To Be Other: 1 Yes 2 No Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 V Other (Specify) After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO 60632 1611 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 CEDAR COLUMBIA BINDU JUSEPH 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State 2012 Registrar

			For	State of Maryla	nd / Depa	irtment of Hea	alth and M	1ental Hy	giene			
			State Registrar		Certificate of Death				Reg. No. 2012			Д
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	Many 28a-	Jirec	MD Baltim 10e. Street and Number	ore City			Baltimore				1 Yes 2 No	\dashv
	with th	Funeral Director	2325 North Monroe Stre	eet		10f. Zip Code	21216		10g. Citizen of V	U.S.A.	y?	
	eath v	nue	11. Marital Status	12. Was Decedent Ever in U		/as Decedent of Hispa	nic Origin? (Spe	cify Yes or No-	14. Race	e - America	n Indian,	\dashv
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 🗶 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.		Yes, specify Cuban, N ☐ Yes 2 No S		Rican, etc.)	Blac Specify:	k, White, et Black		
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ylan	ld be fi Mental arked atic ev	2		Lawrence Brunt				Α	lice Duboi	s		
Baltimore, Maryland 21215-0036	2 shoul th and 27 is m trauma	1	19a. Informant's Name/Relationship (7) Valerie Dargan	/pe, Print)	1	g Address (Street and North Monroe			-	tate, Zip Co	de)	
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mo	Page nent o ant: If ury or		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	i i ioniovai iioni otato		rematory, Inc.	Apr '	18, 2012	Cator	sville,	Maryland	
Balti	permit. Departr Importa any inju		21. Signature of Funeral Service Licens	iles	22	Name and Address o Estep Broth 1300 Eutaw	f Facility ners Funeral Place Baltin	Service, P.	. A. 1217			
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DΪ	tal or is after al Direction		4 - Homicide determined	building, etc. (Speci	fy)			City or Tow	n, State)			ļ
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	To the within To the Somple	Σ	only one) 3 L Certifying Nur. 29b. Signature and title of certifier	se Practitioner: To the best of	rriy knowledge,	29c. License nu	rme, date and pla mber	ice, and due to t	ne cause(s) and m 29d. Date signed	(Month, Da	ıy, Year)	\dashv
			> Matta	IL, MD		17405	7944	0	04/0	6/20	112	
	5		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, P	rint)	St., V	Bout in	or, M	D 2	1201-159	5
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	LXaiiiii		8145 Cyprus Cedar Lane		Ellico	ott City		Howard	
	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth	(ear) Co	rthplace (State or Foreign
	Director		220-56-1306 1 M 2 L F Usual Residence of Decedent	UPO Yrs.			(Month, Day,)	951 Ba	lt. Maryland
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9500-612	s afte ral", c Exam	Completed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates	X NO	1 ☐ Yes 2 😿 No	Specify:		Specify: W	hite
ה כ	hour natur	olete	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	pation	ring 1	6b. Kind of Business	Industry
7	nin 72 ne. than " e Me	omi	Elementary/Seconday (0-12) College (1-4 of the college College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College College	or 5+) life. D	O NOT use retired)	-		Recycle M	atorials
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au	be filed within 72 hours after death with the Maryland ental Hygiene. 'ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	으	Cecil L. Decker, Sr.				te Decker	,	
Maryland	should be file n and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	and Number or Rui	al Route Number, C	City or Town, State, Z	ip Code)
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 2ba or 28a-f show other traumatic event, the Medical Examiner must be notified at		Christopher Decker - Son	4318	Leola Av	enue, Ha	lethorpe,	Maryland	21227
ore			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from St.	20b. Place of Dispo cemetery, crei	matory or other place	ce)		0c. Location - City o	
Baltimore,	t. Page 1 tment of rtant: If it		4 Donation 5 Other (Specify)	Meadowri	dge Mem.	Park 04/	19/2012	Elkridge,	Maryland
Ra	permit. Page Department of Important: If any injury of	0 3	21. Signature Funeral Service Library					ufman F. idge, Mar	yland 21075
			23a. Part 1. Inter the disease, or complications that cau shock, or heart failure. Lift only one cause on each	sed the death. Do not ent line.	er the mode of dyin	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between
	Physician/	i s		11424 de	TILRY	DEFEA	95		Onset and Death
	Medical Examiner		resulting in death) Due to (or	as a consequence of):					
		ner		as a consequence of					
6,	uted id ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c						
)(e exectian ar	al E	resulting in death) Last Due to (or	as a consequence of):					
20	that the death certificate be executed ned by the attending physician and edetached for use as the burial-transit	dical	d						
/α	ertific ding p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes	me of pregnancy				23d. Date of de	aliveny
ROX	atten atten I for u	iciar	in the past 12 months? 1 ☐ Live Bir		Ectopic pregnanceOther (specify)	су		Month Month	Day Year
л Э	the de by the achec	hys	9 Unknown	vn					
Τ.	requires that the death certifics been signed by the attending p should be detached for use as t	by	Part II. Other significant conditions contributing to deat	th but not resulting in the u	underlying cause gi	ven in Part I.			o the cause of death?
Vital Records,	equire een si nould	Completed	Juli Tare Ozerie .	CHUI PL VC					Probably 4 Unknown
ပ္က	has b	mpl	ELGRIST TEUSION				24a. Was an autopsy perform		utopsy findings available completion of cause of
ř	r: The ficate r, pag		25. Was case referred to medical		00 B	In a st Double (Observed)	1 ☐ Yes 2.		s 2 No
Пта	s certi	To Be	examiner?	oatient 2 ER/Outpatie	Oth	lace of Death (Chec		ice 6 Other (Spe	ciful
0	g Phy er this neral c		27. Manner of Death 28a. Date of			y at	28d. Describe how		City)
o	endin eath. or: Aft he fur	fica	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	Bay, reary Injury		Yes 2 No			<u>.</u>
DIVISION	or Att after d Direct	Certificate:	4 Homicide determined 28e. Place of	Injury - At home, farm, str etc. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ro State)	ural Route Number,
_	To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	Medical	29a. Certifier 1 Certifying Physician: To the best (Check 2 Medical Examiner: On the basis)						
	the F	Me	only one) 3 Certifying Nurse Practioner: To 29b. Signature and title of certifier			ne time, date and pla	ce, and due to the c		s stated.
-	F ≥ F 0		>11 // Illipum	12	>	2017	29	2/17/19	7 .
٠	h		30. Name and address of person who completed cause of	ordeath (Item 23a) (Type, I	Print)	0010			21075
	2		MENCHAS MOROGIE	2, 65/8 M	21DOU	righti	D, STEI	O FLYDES	SE MO
	Sta	e	31. Date filed (Month Day Year) APR 2 0 2012	istrar's Synature	7.7		n s	1	
	Registra	ar	MI IS A BANK TOWN	17					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Amend Items 29	State of Marylan	d 526 pe Cei	4 ^t / 12 0/201 tificate of	Health and Death	Mental Hy	giene Reg. No. 201	2 12362
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day Yea	3. Time of Death
- nee	/Medic	al	Rosalee Jean Dreye 4a. Facility Name (If not institution, give str			Ab City Town	or Location of Deat		ry 27, 201	
)	Examin	er	Genesis Long Green	,		Balti			40. Obdity of Bo	atti
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	th 9. B	irthplace (State or Foreign Country)
н	Director		218-32-3574	M 2	76 Yrs.			July 1		aryland
vland	wor		10a. State 10b. County	10c. City	, Town or Lo					10d. Inside City Limits
e Mar	Sa-f si	Director	MD		Balt:	imore				1 ∑Yes 2 □ No
with th	a or 2		10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
leath y	ns 23	Funeral	5243 Reisterstown F	Coad . Was Decedent Ever in U.S	S. 13. V	2121 Was Decedent of	Hispanic Origin? (S	Specify Yes or No	USA 14. Race - Ar	nerican Indian,
6	or iter		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 M No If Yes, Give		fYes, specify Cul I∐Yes 2∭ No	oan, Mexican, Puer	to Rican, etc.)	Black, Wh Specify: W	· l
003	ural",	d by	3 X Widowed 4 □ Divorced	Year or Dates:						
d 21215-0036 filed within 72 hours after death with the Marvland	n "nat	Completed	15. Decedent's Educa (Specify only highest grade of	completed)	16a. Deced (Give life. I	dent's Usual Occu kind of work done DO NOT use retire	ipation e during most of wo ed)	rking	16b, Kind of Busines	s/industry
212	giene er tha	mo.	Elementary/Secondary (0-12)	College (1-4or 5+)		vaitress			food inc	lustry
ind e	d othe	Be	17. Father's Name (First, Middle, Last)						, Maiden Surname)	
	h and Mental Hygiene. 7 is marked other than traumatic event, In Market Market.	은	Milton Harry Jeffe 19a. Informant's Name/Relationship (Type		10h Mailir	ng Address (Stree		e Audrey	er, City or Town, State	Zin Cade)
, Ma and 2 s	Health an		Kenny Dreyer/son	, rung	1		a Street			
• •	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☒ Donation 5 ☐ Other (Specify)		lace of Dispo emetery, cren	sition (Name of natory or other pla	ace)	Date	20c. Location - City	or Town, State
Balti	Departm Importa any Inju		21. Sign and Starting Censes Cona	deffrector			ess of Facility Comy Boar MD 212		Baltimore	Street
			23a. Part 1 Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death cause on each line.	. Do not ent	er the mode of dy	ring, such as cardia	c or respiratory a	ırreşt,	Approximate Interval Between Onset and Death
	nysician		Immediate Cause (Final disease or condition	METASTAT	10 5	PUMMON	5 CES (CANCING	AM	Offset and Death
	Medical xaminer		resulting in death)	Due to (or as a consequ		£ 77	F PA	LIZ		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ		(1)		(3)4		
cuted	nd ransit	Examiner	that initiated events C.							
60 , be exe	physician and the burial-transit		resulting in death) Last	Due to (or as a consequ	ience of):					
68760 ificate be e	physi s the t	edical	d .							
 Box 68760, death certificate be executed 	attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		∃Ectopic pregnar	201		23d. Date of	delivery
O. B he deat	the att	sicia	in the past 12 months? 1 ☐Yes 2 ☐ No	4 Pregnant at time of d		Other (specify)			Month	Day Year
o. ‡	ed by the detached		9 ☐ Unknown Part II. Other significant conditions contr	ibuting to death but not resu	Ilting in the u	nderlying cause g	iven in Part I.	23e. Did	tobacco use contribute	to the cause of death?
rds,	n signed l	d by	KIDNIZY TAIL	re				1 12	Yes 2 No 3□	Probably 4 🗌 Unknown
DCO aw rec	s been s	olete	/					24a. Was	an 24b. Were	autopsy findings available
The L		Completed						auto perfo 1 □ Yes	ormed2/ death	o completion of cause of ? es 2 □ No
Vita iclan:	certificate rector, pag	Be (25. Was case referred to medical examiner?	spital:			har	ath (Check only		
Vision of Vita Attending Physician;	r this erral din	7: 10	1 ☐ Yes 2 ☑ No Ho:	1 Inpatient 2 ☐	ER/Outpatier 28b. Time o	IL 3 LI DOM		1	idence 6 Other (S	pecify)
lon ding	After funer	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	Wo	ork? ⊒Yes 2.⊒No		,,	
Division of Vital Records,	a er death Director /	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	me, farm, str	eet, factory, office		28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
Div To the Hospital or	ours ieral filled		29a. Certifier 1 Certifying Physic	clan: To the best of my kno	wledge, deat	h occurred at the	time, date and place	ce, and due to the	e cause(s) and manner	as stated.
he Ho	within 24 h To the Fun coπpletely	edical	(Check only 2 Medical Examine one)	er: On the basis of examina and manner stated.	tion and/or in	vestigation, in my	opinion, death occ	curred at the time	, date and place, and o	lue to the cause(s)
To ti	within To the сотры	ž	29b. Signature and title of certifier				nse number		29d. Date signed (Mo	
			July 44	MD	000 /7	D0047			April 19,	2012
	2		30. Name and address of In who com	ipleted cause of death (Item	123a) (Type,	Flyoce	AUR I	BALTI MA	re ZI	212
	Sta		31. Date filed (Month, Day, Year)	pleted cause of death (item	ture					
	Registr	ar	APR 2.0.2012	Charles A.	MICHE					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G926 4/25/2012 JH State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Clarence H. Dizard 205PM Medical ton 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sina. Hospital 1 1 masa IMME 8. Date of Birth (Month, Day, Year) 07/12/1944 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 158-32-2783 X 1 M 2 D F Hours New Jersey 67 Director Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director injury or other traumatic event, the Medical Examiner must be notified 1 X Yes 2 □ No MD Baltimore Pikesville 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7509 Shelowood Road 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes y 2 X No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Specify. Completed Black 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Teacher Education Be Maryland Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clarence Dizard Dorothea Wrav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valeria Dizard / Wife 7509 Shelowood Road, Pikesville, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 N Cremation 3 Removal from State Chesapeake Crematory 4/17/2012 4 Donation 5 Other (Specify) Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner on of eation Sequentially list conditions, Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed CERTIFICATION ASPROVED BY NEUTCAL EXAMINER Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Division of Vital Records, P.O. Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Yes 2 No ed by the a detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Diabetes 2 No M 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မှ 1 NInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred ☐ Natural 5 Pending 1 Yes 2 XiNo 2 Accident MArch 2011 Investigation 6 Could not be Un Krown M Fall after deat Director: Suicide
Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) b 24 hours after Funeral Directletely filled in b Hone Pikesvillemo 7509 3 he llowsod Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 To the I 3 Sertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 48732 10,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CR M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 12364 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death April Physician/ 201^{Year} 1:14 A M Diehl. Sr. Robert August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Greater Baltimore Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 217-24-2984 1 🛛 M 2 □ F 82 Sept. 7,1929 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits filed within 72 hours after death with the Maryland al Hygiene. 10a. State 10h County 10c. City, Town or Location Director 1 🗆 Yes 2 🔀 No Maryland Baltimore Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21131 U.S.A. 10 Glenbrook Drive 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give 1950-1953
Year or Dates. Black, White, etc. þ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Completed White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Senior Engineer Gas & Electric Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Diehl Esther Mae Moffitt August 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phoenix, 10 Glenbrook Drive Maryland <u>Dorothy Mae</u> Diehl Wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4-21-2012 Parkwood Cemetery Parkville Maryland 4 Donation 5 Other (Specify) Dignature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Towson, Maryland 1050 York Road 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYGCINAS Infarction Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PNEWMONI Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate | 1 Yes 2 No Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) 27 No Hospital Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Director: A Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral I Medical 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar 54

Scutt Adam Ruad

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

	_	For	State of Marylan	d / Depa	artment of H		_		gible.	1000	
		State Registrar 1. Decedent's Name (First, Middle, La	st)	Cer	tificate of L	Death	2. Date of De	Reg. No.	2012	236 3. Time of Death	
hysiciar Medica Examina	al .	Cherk Sang Dea			4b. City Town, or	Location of Death	APRIL	Day 4c Cour	2012 nty of Death	9:59 PM	
uneral	•	SAINT TOSEPH 5. Social Security Number 6.5			, ,	SON If Under 24 Hrs.	8. Date of Bir	BH	LTIMO	lace (State or Foreign	
ector		554-46-5768 Usual Residence of Decedent	1 X M 2 □ F 85	Yrs.	Months Days	Hours Min.	9/6/19	y, Year)	Chin	ry)	
important. It can set it is marked outer trial and any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10a. State 10b. County Maryland Baltimo		, Town or Loo imoniu					1	0d. Inside City Limits 1 ☐ Yes 2 🏖 No	
ist be no		10e. Street and Number 8 Teaneck Court			10f. Zip Code 21093			10g. Citizen d	of What Coun	try?	
Examiner mu	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.	l:	Vas Decedent of H f Yes, specify Cuba	ın, Mexican, Puèrti		В	14. Race - American Indian, Black, White, etc. Specify: Chinese		
	Completed	15. Decedent's l (Specify only highest g Elementary/Secondary (0-12)		(Give I	lent's Usual Occup kind of work done of NOT use retired)		king		f Business/Inc		
	o l	17. Father's Name (First, Middle, Last) Bing Young Dea	4	0wne	r	18. Mother's Nar			Cleane	<u>r</u>	
Der traumar		19a. Informant's Name/Relationship (Bill Dea / Son		8 Te	g Address (Street a		onium, M	lary1an	d 2109	3	
; ; fm		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	lace of Dispo emetery, cren laney	sition (Name of natory or other place Valley Me	em. 4/28	Date 3/2012		on - City or To	_{wn, State} aryland	
once.		21. Signifund of Emeral Supplies	Min		Name and Addres		ick Tows Towson,			ome, Inc. 04	
₌n/ cal	/ //	23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		REST	er the mode of dyin	g, such as cardiac	or respiratory ar			Approximate Interval Between Onset and Death	
ier	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Acute My Due to (or as a conseque C. CORONAR Due to (or as a conseque d.	ence of):	DIAL IN ETERY	DISEAS	ION SE				
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	Ectopic pregnance Other (specify)	Э			Date of delive	ery Day Year	
		Part II. Other significant conditions of LAC TIC ACI	contributing to death but not resi	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did t		_	e cause of death?	
bage 2 should be det	Completed by	RENAL INS		34			24a. Was auto perfo 1 \(\sum \) Yes	an 24l psy prmed?	b. Were autop	osy findings available appletion of cause of	
		25. Was case referred to medical examiner? 1 ☐ Yes 2 📈 No	Hospital: 1 Minpatient 2	ER/Outpatier	Lou	ace of Death (Che			other (Specify)		
		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	y at	28d. Describe I				
		3 ☐ Suicide 4 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State)									
	Medical	(Check 2 Medical Examonly one) 3 Certifying Nu	vsician: To the best of my knowled niner: On the basis of examination rse Practitioner: To the best of m	and/or invest	igation, in my opinio death occurred at t	on, death occurred the time, date and p	at the time, date a	and place, and the cause(s) an	due to the cau d manner as s	se(s) and manner stated tated.	
.		29b. Signature and title of certifier	1 10	W	29c. License	826		29d. Date sign	8 1 2		
		Pricher	& Limithic	لاس_	$- \nu\rangle$	000					
completely filled in by the funeral director, page 2 should be detached for use as the burian	e	30. Name and address of person who RICHARD LINTA 31. Date filed (Month, Day, Year)	completed cause of death (Item // Cum, M.D. 32. Registrar's Signat	23a) (Type, F 760) ure	rint) OSLER	DRIVE	70W5C	N, M	HRYLA	ND 21204	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ MARGARET ANN TRACEY DANNENMANN 9:25 PM April 16 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Manorcare Nursing Home-North Charles Baltimore County Towson 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Month, Day, Year Jan 13, 1 220-32-2904 Months Days Hours Min. **Director** 1 □ M 2 🗓 F Maryland 1926 86 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County notified at Director 1 ☐ Yes 2 🔀 No Maryland Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 21204 7001 North Charles Street USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black. White, etc. 1 Never Married 2 Married by Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elmer Marshall Tracey Edna Pearl Hunt other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 str Department of Health ar Important: If item 27 is any injury or other trau Timonium, MD 21093 2107 Suburban Greens Drive, James J. Dannenmann (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Green Mount Crematory 4/19/2012 Baltimore, Maryland 21. Sign We of Fun ral S. Lawson MITCHELL WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death BRILLAT Ph sician/ DA TRIAL disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or). Exami The law requires that the death certificate be executed physician and sthe burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day 1 ☐ Yes 2√Z No g ☐ Unknown ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DEBILITY 1 Yes 2 No 3 Probably W Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? ANEMIA 24a. Was an has autopsy perform this certificate 1 ☐ Yes 2 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After To the Hospital or Attending 1 Natural 5 Pending work? r death. 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined hours after within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

DHMH 17 Rev 06-2011

State Registrar Bellona

empleted cause of death (Item 23e) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10d, e&f Per FH G926 4/20/2012 Figure 3 and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician '** \ni 2:40 P M CELINE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LEVINDALE HEBREW HOME BALTIMORE N/ADate of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 214-44-6762 Director MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County E¥es XXXNo Funeral Director BALTIMORE HIMORE 10g. Citizen of What Country? 10e. Street and Number 2900 Stone Cliff Drive #408 10f. Zip Code "natural", or items 23a or 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or ite iny or other traumatic event, the Medical Examine. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: WHITE Specify ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) SALES RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BARNETT မ SHPRITZ MARY EDELSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AARON DONNER / SON 7523 SLADE AVENUE, BALTIMORE, MD 21208 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH TFILOH CONG. 4 ☐ Donation 5 ☐ Other (Specify) 04/19/2012 BALTIMORE, MD 21. Sign vire of Funeral Service Liceus 22. Name and Address of Facility $\,$ SOL $\,$ LEVINSON & $\,$ BROS., $\,$ INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician month Ongestive /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dust to (or as a dunsequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 740 1 TYes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 🗌 Yes 2 □ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) within 24 and mariner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W Behrdore erndole-

DHMH 17 Rev 1/2001

State Registrar

) 2010 12-02 Unk (on	Please Type or Print in Black in State of Maryland / Depa	rtment of	Health and			egible		7 1	2	236
			1- For State Registrar 1. Decedent's Name (First, Middle,Lest)	tificate of	Death		2, Date of D	Reg. No.			3. Time of I	
Med	Physicia ical Exami		David Gregory		Elev		Month April 16		Year		0830 h	
			4a. Facility Name (if not institution, give street and number) 3337 Cliftmont Avenue	4		Location of Death		4c.	County of			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days		_		1	Foreign		
	Director		219-50-0370 1X M 2 F 65 Usual Residence of Decedent	Yrs.			04	06	47	Cour	ntry)	MD
	nd how any cc.	_	10a. State 10b. County 10c. City,	Town or Location						- 1		City Limits 2 No
	Aaryland 28a-f show	Director	10e. Street and Number		10f. Zip Code	-		10g. Citiz	zen of Wha	t Countr	y?	
	h the N		3337 Cliftmont Ave		212				U.S			
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at occ.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	S. 13. Was	Decedent of His s, specify Cuban,	panic Origin? (Sp Mexican, Puerto	ecify Yes or Rican, etc.)	No-	14. Race - White,		an Indian, B	3lack,
	after d	P. F.	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 X No				Specify:		ack	
	hours natur		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			on (Give kind of v DO NOT use reti			(ind of Busi eate)			more
	36 hin 72 e. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade 2yrs	OR At	tendan	t			dica:			
	5-00 ed wit fygien other	20	17. Father's Name (First, Middle, Last)			8.Mother's Name	(First, Middle					_
	121; d be fill ental I arked	BB	Renze Eley	I 40h Mailine		Louise			tu or Tour	State 7	Zin Codo)	
	MD 21215-0036 d 2 should be filed within 7 Ith and Mental Hygiene. n 27 is marked other than numatic event, the Medical	၉	19a. Informant's Name/Relationship (Type, Print) Lisa Eley-Cousin			e Dr.,						878
	Pe, No. 1 and 2 Health Fitem 2 rr trau			Place of Dispositions or other controls.	tion (Name of cen	netery,	Date	20c. l	ocation - C	City or To	own, State	
	Pages nent of ant: If		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	On-Sit	e .		20/20	14 в	alti	mor	e, M	d
	Baltimore, permit. Pages 1 an Department of Hea Important: If itel		21. Signature of Funeral Service Licensee	Man	eme and Address	of Facility West	D-14			MΑ	2121	5
	Physician		23a. Part I. Enter the disease, or complications that caused the death.	Do not enter th	e mode of dying,	sh Ave a	r respiratory	arrest, sho	ck, or hear	t		ate Interval
	/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiov	ascular Dise	ease							Onset and eath
1	_Xammet		or condition resulting in death) Due to (or as a consequence or b.	f):								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	f):								
0	uted d ansit	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of d.	f):			<u> </u>					
	Box 68760, e death certificate be executed the attending physician and ed for use as the burial - trans	edical	UNPENDED AMENDED									
	Box 68760, a death certificate be the attending physical for use as the bu	/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of preg		aldeath 3	Ectopic pregna	nev		d. Date of do	lelivery Da		Year
	x 68 h certif tending use as	Physician/M	past 12 months?	oth -	aldeath 3 [ner(S <i>pecify</i>)			33-2	Mortan	Du	9	1001
	BO) ie deati	hysi	1 Yes 2 No 9 Unknown g Unknown	10 - 1- 1b			220 Die	tobacco	use contribi	ute to th	e cause of	death?
	P.O.	by P	Part II. Other significant conditions contributing to death but not re	esuiting in the u	ngeriying cause g	iven in Part 1.		-	No 3	_		
	ds, equires	eted		<u> </u>			24a. W					gs available
	e law r e has b ge 2 sh	Completed						topsy rformed? s 2 N	de	eath?	mpletion of	
	I Re 10: Th rtificat tor, pag		25. Was case referred to medical		26.Place	of Death (Check		<u> </u>	7 1	7 100		
	Vita hysicia this ce	ro Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient	U		g Home 5		nce 6 🗸		Scene	
	n of diog P h. After e funera	inoi	27. Manner of Death 1 ✓ Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	28b. Time of Ir		y at Work? /es 2 No	28d, Describ	oe how inju	ry occurred	d		
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physiciae: The law requires that the death certificate be within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri-	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	ome, farm, stree		_	28f. Location or Town		nd Number	or Rura	Route Nu	ımber, City
	the Hospit hin 24 hour the Fucers	Medical Ce	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination a									
	To with To Cor	Me	29b Signature any title of certifier	1050	29c. Licens O.C.I		<u>-</u>		Date signed		h, Day, Yea	ır)
5			30. Name and address of person who completed cause of death (Item Victor Weedn MD JD Assistant Medical Examin		. Baltimore S	treet, Baltimo	re, MD 21	223				
		tate	31. Date filed (Month, Day, Year) 32. Registrar's Signat									
24	Regis		APR 20 2012 General B. Ago	ELE								
	HMH 17 Rev 1/2 CME 2006	2001	OCME	ORIGINA								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 12369 State Registrar Certificate of Death 3. Time of Death **3**: **28** P M Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 ETHEL EUENTO suil Medical 4a. Facility Name (if not institution, give street and nur 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ENVOY OF PIKESVILLE PIKESVILLE BALTIMORE Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Days Hours 12702/1908 Country) 103 Yrs. MD Director 212-16-0128 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No BALTIMORE BALTIMORE MD 10f. Zip Code 10e. Street and Number ò 10g. Citizen of What Country? Funeral items 23a 3429 JANELLEN DRIVE 21208 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced "natural" Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ene. College (1-4 or 5+) Elementary/Seconday (0-12) MUSIC TEACHER EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H 2 permit. Page 1 and 2 should be RICHMOND LOUIS SOPHIE MORGANSTERN traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau RICHARD EVENTOFF/SON 3429 JANELLEN DRIVE, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ARL'INGTON CEMETERY-X Burial 2 Cremation 3 Removal from State 04/19/12 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) CHIZUK AMUNO CONG. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Par 1. Enter the disas shock, or heart ailure ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, . List only one cause **o**n each line. Onset and Death Immediate Cause (Final Physician/ DEMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician Be Completed by Physician/Medical

Certificate: To

4 Homicide

only one)

29a. Certifier

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow
		24a. Was an autopsy performed? 1 \[\sum \text{Yes} \ 2 \sum \text{No} \] 24b. Were autopsy findings available prior to completion of cause of death? 1 \[\sum \text{Yes} \ 2 \sum \text{No} \] 1 \[\sum \text{Yes} \ 2 \sum \text{No} \]
25. Was case referred to medical	26. Place of Death (Check or	nly one)
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence 6 Other (Specify)
27. Manner of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident Investigati	(Month, Day, Year) injury work? on M 1 ☐ Yes 2 ☐ No	Describe how injury occurred
3 Suicide 6 Could not	28e. Place of Injury - At home, farm, street, factory, office	. Location (Street and Number or Rural Route Number,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

24 hours a

Medical

building, etc. (Specify)

688852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

2835 Smith AUENUE DIAMOND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 12370 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRTL 18,2012 MARIE L. FAIR 12:01A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TIMONIUM BALTO. STELLA MARTS al Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 213-01-6677 **Director** 1 🗆 M 2 🔀 F 95 2-7-1917 MARYLAND Usual Residence of Decedent 28a-f show the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the <u>Medical Examiner must be</u> notified at 10c. City, Town or Location Director 10d. Inside City Limits MD. BALTO. **ESSEX** 1 ☐ Yes 2 😿 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2706 HOLLY BEACH ROAD 21221 USA and Mental Hygiene. is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: 3 □XVidowed 4 □ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOHN F. BOTZON EMMA G. JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLORIA J. FAIR-PINEDA DTR. 2706 HOLLY BEACH ROAD ESSEX.MD.21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OAKLAWN CEMETERY 4-20-2012 BALTO.MD. . Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Medical Examiner Physician/Medical P.O. Division of Vital Records, To the Hospital or Attending Physician: The law requires

12:01

2012

APRIL

FAIR

Medical Certificate: To Be Completed by

disease or condition resulting in death)	a. ALZHEIMER'S	DISEASE			- 6	
resulting in death)	Due to (or as a consequ	ience of):				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	rence of):				
Cause (Disease or Injury that initiated events resulting in death) Last	C. Due to (or as a consequ	ence of):				
	d	<u> </u>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of c	death 3 Ectopic pred	nancy fy)		23d. Date of deliv Month	rery Day Year
Part II. Other significant conditions of	contributing to death but not res	ulting in the underlying caus	se given in Part I.	\ \ \ \	ouse contribute to t	he cause of death?
				24a. Was an autopsy performed?	prior to co death?	psy findings available ompletion of cause of 2 \square No
25. Was case referred to medical examiner?		2	6. Place of Death (Check	conly one)		
1 ☐ Yes 2 👿 No	Hospital: 1 lnpatient 2	ER/Outpatient 3 DOA	Other: 4 Nursing Ho	me 5 Residence	6 X Other (Specify	HOSPICE
27. Manner of Death 1	(Month, Day, Year)	injury	Injury at work? 1 □ Yes 2 □ No	28d. Describe how inj	ury occurred	
3 □ Suicide 6 □ Could flot 2		me, farm, street, factory, of	ice	28f. Location (Street a City or Town, Sta		l Route Number,
(Check 2 L Medical Exam	sician: To the best of my knowliner: On the basis of examination se Practitioner: To the best of m	and/or investigation, in my	pinion, death occurred at	the time, date and place	ce, and due to the ca	use(s) and manner stated.
29b. Signature and title of certifier		29c. Lid	ense number	29d. D	ate signed (Month,	Dav. Year)

R130272 | 4/18/20/2

TIMONIUM, MD 21093

State Registrar

filled in by

within 2 **To the** I

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

TRACIE L. MORGAN,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of M	/laryland		artmen tificate			and N		giene Reg. No. 2	012	12371
Physicia Medic		1. Decedent's Name (First, Middle, La: Georgia Mary Fi	,							2. Date of Dea Month April	17, Day	2 Year	3. Time of Death 12:31 A M
Examin		4a. Facility Name (if not institution, give Arden Courts	street and number)					Location			4c. Count	y of Death	
Funeral Director		Usual Residence of Decedent	ex	ge (In yrs. Ia.	Yrs.	If Under Months		If Under Hours		8. Date of Birtl (Month, Day September	(, Year)	Min	nesota
Maryland 28a-f sh otified a	Director	Maryland Montgom	nery	10c. City	, Town or Loc	ensir	igtor	n				1	0d. Inside City Limits 1 Yes 2 No
n with the	Funeral D	10e. Street and Number 4301 Knowles Ave	nue			10f. Zip		895			10g. Citizen of United		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates.	?	lf.	Vas Deced Yes, spec	fy Cubar	n, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)		ce - America ck, White, e	etc.
vithin 72 hou jiene. er than "nat the Medica	Completed	15. Decedent's E (Specify only highest grant properties) Elementary/Secondary (0-12)		5+)	life. DO	ent's Usua kind of wor D NOT use	k done di retired)	tion uring mos	t of worki	ing	16b. Kind of E	Business/Inc	lustry
uld be filed v I Mental Hyg narked othe	To Be	17. Father's Name (First, Middle, Last) Charles Henry De								e (First, Middle, I			
nd 2 shou lealth and m 27 is n		19a. Informant's Name/Relationship (T James Fitzpatric								Noute Number,			,
t. Page 1 a tment of H tant: If ite ijury or otl		20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specin	fy)	e Mon	ace of Dispos metery, crem Lgomer natori	natory or of	e of her place nc.	e) .	Apri 20	1 21, 12	20c. Location Bethes	,	wn, State aryland
permir Depar Impol any ir		21. Signature of Fundat Service Licence		01619	Rol 75	Name and Dert A 57 Wi	Address Puni SCOT	phrey sin	Funer Aven	al Home, ue, Beth	Bethesda hesda,	-Chevy Maryl	Chase, Inc. and 20814
Physician/ Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	plications that cause one cause on each line. Pneumo Due to (or as	nia		r the mode	of dying	, such as	cardiac c	or respiratory arre	est,		Approximate Interval Between Onset and Death
Examiner susit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Chroni Due to (or as			ve Lu	ng D	isea	se				
ate be execu bhysician and the burial-tra		that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):								
To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 🗌 Fetal at time of de	death 3 🗌	Ectopic p Other (spe						ate of deliver	ry Day Year
quires that t en signed b ould be deta	by	Part II. Other significant conditions of	ontributing to death I	but not resu	Iting in the ur	nderlying c	ause give	en in Part I	l.				e cause of death? ably 4 Unknown
: The law re cate has be r, page 2 sh	Completed									24a. Was a autops perform 1 X Yes	sy med?		sy findings avallable ipletion of cause of
nysician iis certif I directo	To Be	25. Was case referred to medical examiner? 1 🖾 Yes 2 🗌 No	Hospital:	tient 2 🗆 E	R/Outpatient	3 DO	Other	e of Deat		only one) me 5 \square Reside	ence 6 X Oth	er (Specify)	Asst. Liv.
or the Pospital or Attending Physician: within 24 hours affected death. To the Funeral birector After this certific completely filled in by the funeral director,	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not b			28b. Time of injury	M 28	c. Injury work? 1 \(\supers	at	1	28d. Describe ho			
ital or Att irs after d ral Direct		4 Homicide determined	building, et	c. (Specify)						28f. Location (St City or Town	n, State)		
tne Hosp hin 24 hou the Funer npletely fil	Medical	only one) 3 L Certifying Nurs	i ner : On the basis of e	examination a	and/or investi-	gation, in m death occu	y opinior rred at the	i, death oc e time, dat	curred at	the time, date an	d place, and du	e to the caus	se(s) and manner stated.
o vitl		29b. Signature and title of certifier					License i D640			2	9d. Date signe April		
8		30. Name and addless of person who o	na, M.D.	11125	Rockv	,	Pike	#11	0, R	ockville	e, Mary	land 2	20852
Stat Registra	_	31. Date filed (Month, Day, Year)	32. F. gistr	ar's signatu									

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760 (2,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Brian Keith Giacubeno State of Maryland / Department of Health and Mental Hygiene 2012 12372 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3 Time of Death Month Day April 17, 2012 Medical Examiner 1241 hrs Keith Giacubeno Brian 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3208 Wheaton Way Apt. I Ellicott City Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. B. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Months Davs Hours Min. Director Country) 217-96-4069 1 X M 2 F 46 Yrs August 16,1965 Maryland Usual Residence of Decedent E V 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland Baltimore Essex 28a-f sho it. Pages I and 2 should be filed within 72 hours after death with the Maryland frment of Health and Mental Hygiene.

retant: If item 27 is marked other than "matural", or items 23a or 28a-f sho y or other traumatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1816 Middleborough Road 21221 USA uneral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 Never Married 2 2 X No Yes Specify: White 1 Yes 2 X No specify: 4 X Divorced If Yes, Give Year 3 Widowed ≦ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Itimore, MD 21215-0036 12 years Self-Employed Musician 17. Father's Name (First, Middle, Last) 1B.Mother's Name (First, Middle, Maiden Surname) Be Roy Giacubeno Gundy Szczepanik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy Giacubeno 1816 Middleborough Road, Essex, Maryland Father 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State April 20. 1 X Burial 2 Cremation 3 Removal from State Holly Hill Memorial Middle River, Maryland 2012 4 Qonation 5 Other Specify 21. ign tur of uneral Service ace 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. M Fig. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart finere. List only one cause on each line. Mixed Narcotic (Oxycodone and Fantany1) Intoxication Approximate Interval Physician Between Onset and /Medical Death Immediate Cause (Final disease and Methadone Use Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed rsician/Medical AMENDED 23a, 27, 28a-f, per me, g927 5-23-12 sm X UNPENDED attending physician for use as the burial Box 68760, IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. <u>á</u> 1 Yes 2 No 3 Probably 4 V Unknown Completed certificate has been sector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Division of Vital Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene this ER/Outpatient 3 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 _ Natural unknown 5 Pending 1 Yes 2 X No Director: death. fd 4-17-12 fd 7:30 am 2 Accident Investigation in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3208 Wheaton Way.

Apt 1 Ellicott City, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 24 hours after e Funeral Direc 3 6 X Could not be Suicide determined (Specify) 4 Found: Residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal To the I within 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. April 18, 2012 Well 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

2012

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Barbara A. Gallagher Month. Physician/ 30A M 2012 9 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore NA 6001 Belle Vista Avenue Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 70 220-38-5968 **Director** 1 □ M 2 🛣 F January20,1942 Maryland Usual Residence of Deced 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified NA Baltimore 1 XYes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral United States of America 6001 Belle Vista Avenue 21206 within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married ð Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. Completed 3 Divorced 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry h and Mental Hygiene.
7 is marked other than "r (Give kind of work done during most of working Johns Hopkins life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hospital 12 Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce, Calvert Lee Bowen, Therese Wilhelmina Malkmus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Eugene Callagher, Sr.-Spouse 6001 Belle Vista Avenue, Baltimore, Maryland 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery April23,2012 Baltimore, MD Signature of Funeral Service License 2. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between end. stage (OPD Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **E**xaminer Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 this certificate 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 🖪 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Fractification | T. the set of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) als Kay april LEMD DO057465 4/10/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 203 Baltimore MD 2120 9. 2835 Smith AV NS Raycopall semo

DHMH 17 Rev 06-2011

Registrar

APR 2 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2012 14:08 M EDORA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 65 Yrs. 7, Maryland 1946 **Director** 212-46-5616 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country 10f. Zip-Code 21043 United States 3310 Sonia Trail Apt#103 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 XNo 1 Yes 2 No If Yes, Give Year or Dates: Specify White 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jane Ellen Woods Paul Handler ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3310 Sonia Trail Apt#103,Ellicott City,Maryland21043 Stephen W. Gruyin/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Apr. 18, 2012 Baltimore, Maryland New Cathedral 21. Synature uneral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. am 1328 Sulphur Spring Road Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ischemic Cordionyopathy disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury Examiner Due to (or as a consequence of) ician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Physician: The law requires that the death certificate be the IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) signed by the at ald be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 T Yes 2 No 3 Probably 4 Unknown Should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page performed? 2 No 1 Yes 2 🗌 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 No Other: 4 \square Nursing Home Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 2 5 Residence this . Manner of Death 1 Natural 28a. Date of Injury Time of 28c. Injury at Work? 28b. 28d. Describe how injury occurred Certification: Director: After or Attending 5 Pending investigation (Month, Day Year) Injury death. 1 \square Yes 2 □ No 2 Accident the 3 🗌 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 - Homicide City or Town, State) hours after Hospital within 24 hours

To the Funeral 29a. Certifier 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) **RES** 000 15, 2012

DHMH 17 Rev 1/2001

State Registrar 10

15/10

32. Register's Sig

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physici		1- For State Registrar	Certificate of	Death			0	010 100	
		Decedent's Name (First, Middle,Last)			- 2	Reg 2. Date of Death		3. Time of Death	
cal Exami	iner	inomas Greeley				Month I April 13, 20		2148 nrs	
		4a. Facility Name (if not institution, give street and number) 437 Darby Lane	4	 b. City, Town, or Lo Bel Air 	cation of Death		4c. County of Harford	f Death	
Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY)	9. Birthplace (State or	
Director		214-88-4428 1x M 2_F 49	Yrs.	Months Days	Hours Min.	963	Foreign Country) MD		
y.		Usual Residence of Decedent		<u></u>					
Maryland 28a-f show any d at once.			0c. City, Town or Location	on				10d. Inside City Limits	
yland a-f sh	tor	MD Harford 10e. Street and Number	Bel Air	126 71 2				1 Yes 2 X No	
or 28	Director			10f. Zip Code		10g	. Citizen of Wha	at Country?	
ath with the Maryland items 23a or 28a-f sho st be notified at once.		437 Darby Lane 11. Marital Status 12. Was Decedent E	verin IIS 13 Was	21015 Decedent of Hispa	nic Origin? / Sno		ISA I I I Bass	American ladica Black	
72 hours after death with the Maryland n"natural", or items 23a or 28a-f she all Examiner must be notified at once	Funerai	1 X Never Married 2 Married Armed Forces?	If Ye	s, specify Cuban, N	lexican, Puerto R	tican, etc.)	White,	American Indian, Black, etc.	
offer d	by Fı	3 Widowed 4 Divorced If Yes 2 2 3 or Dates:	X No	Yes 2 _X No s	specify:		Specify:	White	
2 hours afte "natural", Examiner		15. Decedent's Education (Specify only highest grade comp	leted) 16a. Decedent'	s Usual Occupation	(Give kind of wo	ork done 1	6b. Kind of Bus		
thin 72 he. than "r diral E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+ 1 1	Cook	st of working life. D	O NOT use retire	a)	Restaur	ant	
filed within Il Hygiene. ed other that, the M. di	oml	17. Father's Name (First, Middle, Last)	GOOK	- 1.0				ant	
e filed al Hy ced of nt, the	Be C			18.	Mother's Name (F		-/		
Ment mark	To E	Thomas Francis Greeley, Jr. 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street a	verna nd Number or Ru	Lee Hun	r. City or Town.	State, Zip Code)	
12 sho th and 127 is umat	11 9	Verna Greeley - Mother		arby Lane				,, _, _,	
permit. Pages I and 2 should be filed within 72 hours al Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Mcdical Examin		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State	20b. Place of Disposit	ion (Name of cemet				City or Town, State	
Pages nent o ant: I		4 Donation 5 Other Specify:	Atlantic C	*	_ 04/1	18/2012	Glen F	Burnie, MD	
epartn nports jury c		21. Scrature of Funeral Service Liousee	22. Na	me and Address of		nimunek			
	1	slight &	610	O W. MacP	hail Rd.	, Bel A	ir, MD	21014	
iysician Medical		283. Part I. Enter the disease, or complications that caused th failure. List only one cause on each line.	ne death. Do not enter the	e mode of dying, suc	ch as cardiac or r	espiratory arrest	, shock, or hear	t Approximate Interval Between Onset and	
caminer		Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Condition resulting in death)		ase				Death	
		Due to (or as a consequence)							
	'		derice or).						
	ner .	Sequentially list conditions, if any, leading to immediate							
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the Hospital or Attending Physician: The law requires that the death certificate in 24 hours after death. the Funeral Director: After this certificate has been signed by the attending phy pitely filled in by the funeral director, page 2 should be detached for use as the lipletely filled in by the funeral director, page 2 should be detached for use as the lipletely filled in by the funeral director, page 2 should be detached for use as the lipletely filled in by the funeral director, page 2 should be detached for use as the lipletely filled in by the funeral director, page 2 should be detached for use as the lipletely filled in by the funeral director.	edical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Obesity 25. Was case referred to medical examiner? 1 Yes 2 No 1 Pregnant at ting of the death by the death by the death by the death by the death by the determined of the determined of the determined of the determined of the determined of the destroy of the death by the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determined of the determin	uence of): of pregnancy 2 Feta 5 Othe out not resulting in the und 2 ER/Outpatient 2 8b. Time of Inju y - At home, farm, street,	26.Place of 3 DOA Othury 28c. Injury a 1 Yes factory, office build d at the time, date a n, in my opinion, de	Death (Check onliner: Nursing H t Work? No ing, etc. 28	23e. Did toba 1 Yes 24a. Was an autopsy performe 1 Yes 2 yone) Home 5 Re 8d. Describe how 3f. Location (Streor Town, State) te to the cause(some time, date and	Month cco use contribute No 3 24b. We printed No 1 sidence 6 v injury occurred et and Number and manner and place, and due	Day Year ute to the cause of death? Probably 4 Unknown ere autopsy findings available or completion of cause of ath? Yes 2 No Other: Scene Or Rural Route Number, City s stated. to the cause(s)	
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			For	State of	f Marylan			Health and N	Mental Hy	giene			
		_	State Registrar			Cer	tificate of L	Death		Reg. No.	2012	1	2376
	Physicia	ın/	Decedent's Name (First, Middle,	•	/	. 1			2. Date of De Month	Day	Year		of Death
	Medic	al	Bessile 4a. Facility Name (if not institution,		5-AUG-0	2(6	4h City Town o	r Location of Death	April	10	2017	2:5	5PM
	Examin	er	3 / 1	Horp. Hol	Jei)		13 A. City, 10W11, 0	timure (1:47	40.0	ounty of Death		
-	Funeral		5. Social Security Number		7. Age (In yrs. Ia	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th			e or Foreign
	Director		214-62-5949	1 □ M 2 🗶 F	58	Yrs.	Months Days	Hours Min.	(Month, Da	1953	Cour	MD	
	how how	_	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside	City Limits
	arylar 3a-f s ified	Director	MD		Bal	timore							∕es 2 □ No
	or 28		10e. Street and Number				10f. Zip Code		1	10g. Citize	n of What Cou	ntry?	
	s 23a	Funeral	3814 3rd St.				21225			USA			
	death r item ner n		11. Marital Status	12. Was Deced Armed Ford	ces?			ispanic Origin? (Span, Mexican, Puerto		14	. Race - Americ Black, White,		
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Ö	hours natur lical E	Completed	15. Decedent	's Education			lent's Usual Occup			16b. Kind	of Business/In	dustry	
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2	d with lygien ther th	Be C	12			Homer	maker				-emplo	yed	
Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "addical Examiner must be notified at imatic event, the Madical Examiner.	To B	17. Father's Name (First, Middle, La Dale Bain	st)				18. Mother's Nam			rname)		
2	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho is marked other than "hatural", or items 23e or 28a-f sho arumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship	p (Type, Print)		19h Mailir	n Address (Street	and Number or Run			wn State Zin	Codel	
	1 and 2 should be if Health and Men item 27 is marke other traumatic	ΙÍ	Michael Gauger					Baltimo			,,,, o.u.o, 2.p	0000)	
Č.	of Head		20a. Method of Disposition 1		20b. P	lace of Dispo	sition (Name of	ce)	Date	20c. Loca	tion - City or To	own, State	
Ĕ	Page 1 ment of ant: If it		4 Donation 5 Other (Sp		W.	Arund	el Cremat	ory 04/2	1/2012	Odent	con, MD		
Baltimore,	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Lic	ensee	M0145	2 Bi	Name and Addre Biley Fur 023 Annar	ss of Facility Neral Homo Colis Rd.	e and C: . Haleti	remati	ion Ser MD 21	vice, 227	PA
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	y the	hysi	1 Yes 2 No 9 Unknown	9 Unkno									
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	omple	Ž	only one) 3 L Certifying N 29b. Signature and title of certifier	Nurse Practitioner:	10 the best of m	ny knowledge,	death occurred at t				and manner as igned (Month,		
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	1		30. Name and address of person wi		of death (Item	23a) (Type, P	rint)	50 12 Ha		Pier		, ,	
	6		ANDREW I	BUKON	t21	h.D.	3001	So AL HA	JOVER 5	t Bo	Itmore	MD	21005
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	negistra	П	WILL OF TALL		-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ GESELL GERALDINE G. Month / 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Square Hospita eda 0 . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 2 - 8 - 1 9 4 5 **Funeral** Social Security Number If Unde Year If Under 24 Hrs 9. Birthplace (State or Foreign Months Hours 215-46-8174 67 **Director** 1 □ M 2 🕱 F NEW JERSEY ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State Director 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland BALTIMORE ROSEDALE MD 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8309 SAGRAMORE ROAD 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 1 Yes 2 XNo Specify: 3 X Widowed 4 ☐ Divorced WHITE "natural" Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) DISABLED DISABLED Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) to and Mental P t. Page 1 and 2 should be fil rtment of Health and Mental rtant: If item 27 is marked i ည BENTLEY **FALGELLO** GARDINER GENEVIEVE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, KIMBERLEY WEIR/DAUGHTER 8309 SAGRAMORE RD ROSEDALE, MD 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1**X№**urial 2 ☐ Cremation 3 ☐ Removal from State 4 - 20 - 12GARDENS OF FAITH BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME Signature of Funeral Service Licenses 1211 CHESACO AVE 21237 ROSEDALE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) diogen Medical Examiner Sequentially list conditions, if any, leading to in module cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician a I for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day No 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has je 2 s certificate has director, page 2 autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Tes Other: ည 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Accident Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral Medical 29a. Certifier Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 04,18,2012

State Registrar

Ra

9000 FRANKLIN SQUARE DR. BALTIMORE,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAN

AMBAREEN

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month VERNELL GAITHER 2012 4:28 PM APRIL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A BALTIMORE CITY SINAI HUSPITAL OF BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 215-22-4933 Hours Director 1 □ M 2 🗓 F Yrs 10-8-1925 SOUTH CAROLINA 86 Usual Residence of Decedent or 28a-f show notified at 10h County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1

Yes 2 □ No MD. N/A BALTIMORE PAILTER ō 10e. Street and Numbe 10f. Zip Code "natural", or items 23a or edical Examiner must be r 10g. Citizen of What Country? Funeral 21216 USA 2704 ELISNOR AVE. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces þ Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No If Yes, Give 1 ☐ Yes 2 X No Specify: Completed Specify: 3 Widowed 4 Divorced BLACK Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) RETAIL -12--0-HECTZLER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ DAVID GLADNEY CHARITY FEASTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) injury or other BARBARA MOANEY (NIECE) 3903 BARRINGTON RD. BALTIMORE, MARYLAND 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burjal 2 ☐ Gremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST VETERANS 4-27-2012 OWINGS MILLS, MARYLAND JONATHAN D. HIBNER^{2. Name and Address of Facility} PHILLIPS FUNERAL HOME, P.A. MONROE ST. BALTIMORE, MARYLAND 21217 Pot 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ SEBSIS D.44 Medical resulting in death) Due to (or as a consequence of): Examiner URINARY TRACT INFECTION DAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Day Year Pregnant at time of death Month 4 Pregnant
9 Unknown 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION, SEIZURE DISORDER HYPOTHYROIDISM Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 🗹 No Other: ဂ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MBBS APRIL 17, 2012 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUZTANI MBBS SINM HOSPITAL OF BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 0 2012

DHMH 17 Rev 06-2011

Registrar

シャアトングル

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) fonth Physician 11.45PM ecilia Horton 2012 pril /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NorthWest Randallstown Baltimore Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🙀 F Days Hours Director 213-20-8215 Usual Residence of Decedent 06 11 26 MD 10d. Inside City Limits 10a, State 10c. City, Town or Location show ral", or items 23a or 28a-f shore Examiner must be notified at 1 ☐ Yes 2X No Director MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 U.S.A. 9025 Meadow Heights Road Funeral Pages 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 ∭No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black ٥ Specify: 3 Widowed 4 □ Divorced "natural" Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Microbiologist 12th grade Food & Drug Admin. Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 7 is marked c traumatic eve Walter Curtis Annie Mazie Curtis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. Sandra O. Oglesby-Daughter 9025 Meadow Heights Road, Randallstown, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 DXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Catherdral 4/25/2012 Baltimoe, Md 21. Signature of Fineral Service Consee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Exer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis /Medical Due to (or as a consequence of): Examiner tract infection Urinery Sequentially list conditions, if any, leading to infine data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Exami difficile Jestrichum and physician a the burial-t Due to (or as a consequence of) Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2 No 1 ∐Yes 2 🔀 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 X Natural ours after death.

neral Director: A
filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number P67323 anally April, 18,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Anitha Nallu

31. Date filed (Month, Day, Year)

32. Registrar's Signature

S. parker

5401, old court Road, Randallstown,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JOHN W. HUGHES MA 85:80 04 19 2012 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death HARBOR HUSPITAL BALTIMORE Birthplace (State or Foreign Country) . Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 216-34-9091 Director 1 X M 2 □ F 73 05/19/1938 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 U.S.A. 2831 Indiana Street , or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 🗌 Widowed 4 🗌 Divorced Completed White Year or Dates er than "natura , the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) h and Mental Hygiene.

7 is marked other than traumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) 12 Machinist Chemical Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be to Department of Health and Menta Important: If item 27 is marked any injury or other traumatic expressions. Hughes Julie Capler Babe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Alma D. Hughes / Wife 2831 Indiana Street Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park | 04/24/2012 Glen Burnie, MD . Si nature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD MO00918 Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ CANDIDA SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner NEUTROPENIC Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day Year Yes 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2 performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🔀 No Other: Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) RES DO APRIL 19

State Registrar DLUSOLA

10

3001 S HANOUER ST. BALTIMORE, MD 21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OBAYOMI-DAVIES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ April Dorothy Hessenauer 9:30 a M 18 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7307 Tred Avon Road Middle River Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 217-09-3477 Hours **Director** 1 M 2X F 91 May 22,1920 Maryland Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** Md. Baltimore Middle River 1 Yes 2 X No o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7307 Tred Avon Road 21220 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Bace - American Indian Armed Force Black, White, etc. Completed by "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Bookkeeper Retail 11 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ္ Arnold Gerald Schultz Amanda Mary Callender 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other tra once. Denise Amanda Rowe Grandbaughter 6507 Hazelwood Ave. Baltimore, Md. 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 21, cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. Rosedale, Maryland 4 Donation 5 Other (Specify) 2012 21. Signafure of Funeral Service Licer Name and Address of Facility
Connelly Funeral Home of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Imm diate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month Pregnant at time of death Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Tes 2 No 2 No Yes 25. Was case referred to medica Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: Other: ပ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at ol or Attending F s after death. 28d. Describe how injury occurred work? 1 Natural injury 5 Pending 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) -2012

Registrar

30. Mame and address of person who completed,

th (Item 23a) (Type, Print)

Hollifield, Helen inph 402327286,

			For Amen State Amen Registrar	Pleas	se Type or amend State o	Print 23a Mary	in Black pt.T.p	Indelil er me partme	ole Inleged	k. Ens 4–3 lealth	ure A 0-12 and M	II Copie sm 1ental Hy	s Are giene	Legible	2 12382
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	Physicia Medic		1. Decedent's Name Helen		Hollifie	ld						2. Date of De Month	eath Da	2012	3. Time of Death
_	Examin	er	4a. Facility Name (if			4				Location o				. County of Dea	ath
1	Funeral Director		Social Security No. 402–32–7286 Usual Residence of	5	. Sex 1 □ M 2 XX F	7. Age (In	yrs. last birthday Yrs.) If Und Months	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da July 19	ay, Year)	Co	rthplace (State or Foreign ountry) uCky
	ryland I-f show ied at	Director	10a. State Maryland	10b. County N/A		100	c. City, Town or Baltim		J				-		10d. Inside City Limits 1 → Yes 2 → No
	h the Ma a or 28a be notif	al Dire	10e. Street and Num				- IXII CLIIK	10f. Z	ip Code				10g. Ci	tizen of What C	
	ms 23 must	Funeral		ane Avenue					1212		-1.0.0			USA	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status1 ☐ Never Marri3 ☐ Widowed		12. Was Dece Armed For 1 ☐ Yes If Yes, Give Year or Da	ces? 2x No	n 0.5.	If Yes, spe	cify Cuba	spanic Oni n, Mexicar Specify:	ı, Puerto	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whi	
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Mar	should hand 7 is m		19a. Informant's Na				- 1						_	r Town, State, Z	ip Code)
re, I	f Healt f Healt item 2 other		Shellie Rel 20a. Method of Disp		ghter	2	0b. Place of Dis	oosition (Na	me of	- 1		imore MD	1	ocation - City o	r Town, State
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F	Physician/ Medical		23a. Part 1. Enter the shock, or hear Immediate Cause (I disease or condition resulting in death)	t failure. List onl Final	y one cause on each	ch line.At	death. Do not e	ater the mo	de of divino	s such as	cardiac o	r respiratory a	rrest	9	Approximate Interval Between Onset and Death
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. Box 68760	Attending Physician: The law requires that the death certificate be st death. st death. st death. by the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the funeral director.	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 12 - 9 ☐ Unknown	nonths?	23c. If yes, out 1 ☐ Live I 4 ☐ Pregr 9 ☐ Unkn	Birth 2 🗀 nant at time	Fetal death 3	☐ Ectopic		у				23d. Date of de Month	elivery Day Year
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<u>al</u> F	ysician: The is certificate director, pag	Be C	25. Was case referre	ed to medical					26. Pla	ace of Dea	th (Check		ale N	ol In te	S Z LI NO
Ţ	Physic this corral dire	욘	1 X Yes 27. Manner of Death	No	Hospital:		2 ER/Outpat		Othe 28c. Injury	4 ∐ Nu				Other (Spe	cify)
o uo	Attending Ph ; r death. ctor: After thi by the funeral	Certificate:	Natural 2 Accident 3 Suicide	5 Pending Investiga 6 Could no	(Mont	h, Day, Yea	ar) injury		work'			28 d . Describe I	now injur	y occurred	
Division	e Hospital or Attend 124 hours after death e Funeral Director: /		4 Homicide	determin	28e. Place	of Injury - Ang, etc. (Sp	At home, farm, s pecify)	treet, facto	y, office			28f. Location (City or Tov			ıral Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical		■ Medical Exa	hysician: To the be iminer: On the basi urse Practitioner:	s of examin	nation and/or inv	estigation, ir	my opinio	n, death oc	curred at	the time, date	and place	, and due to the	cause(s) and manner stated.
	To the within 2 To the comple		29b. Signature and t	itle of certifier		44.0			c. License				29d. Da	te signed (Mont	
	3		30. Name and addre		o completed caus	M·O e of death			HIS				M	111/2013	J
	<i>-</i>	0	Khimben 31. Date filed (Month	n, Day, Year)	Santido 32. Re	o distrar's S	W·D ₂	132/11	WOWE	M	0				
3.	Stat Registra		APR	2 0 201	2 Senes	v k	(Item 23a) (Type	es.						_	

Please pe or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 15⁹ay 0:30 P Ø2pth 201º2 Laureen Ellen Hamilton Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air 30 pm / 303 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 215-76-7401 1 🗆 M 2 😾 F Director 01/11/1969 Maryland 43 Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director MD Harford 1 🗌 Yes 2 🔀 No Abingdon 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 21009 USA 3025 Benefit Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Was Decedent Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: White "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) If Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Pharmacy Tech Food Store n and Mental Hygier ? is marked other 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joanne Charlotte Wolfe Gerald Anthony Nuth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau 3025 Benefit Court, Abingdon, MD 21009 Robert D. Hamilton - Spouse 20a. Method of Disposition
1 ☑ Byrial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 4 ☐ Danation 5 ☐ Other (Specify) Jarrettsville Cemetery 04/19/2012 Jarrettsville, MD 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, re of Funeral Service Lie 21. Sign 610 W. MacPhail Rd., Bel Air, Maryland 21014 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Cancel Colon Immediate Cause (Final Phylician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-trar Due to (or as a consequence of): Physician/Medical 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year the a 1 Yes 2 s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Haminor 2 No 3 Probably 4 Unknown Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 CNO 1 Yes Division of Vital 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No Inpatient 2 ER/Outpatient 3 DOA ပ 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

Le Funeral Director: Aft

oletely filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continuing Nurse Practitioner To the cause (s) and manner stated continuing Nurse Practitioner To the cause (s) and manner stated continuing Nurse Practitioner To the cause (s) and manner stated continuing Nurse Practitioner To the cause (s) and manner stated continuing Nurse Practitioner To the cause (s) and manner stated continuing Nurse Practitioner To the cause (s) and manner stated continuing Nurse Practitioner To the cause (s) and manner stated continuing Nurse Practitioner To the cause (s) and manner stated continuing Nurse Practitioner To the cause (s) and manner stated continuing Nurse Practitioner To the cause (s) and manner stated continuing Nurse Practitioner To the cause (s) and manner stated continuing Nurse Practitioner To the cause (s) and manner stated continuing Nurse Practitioner To the cause (s) and manner stated continuing Nurse Practitioner To the cause (s) and manner stated continuing Nurse Practitioner To the cause (s) and manner stated continuing Nurse Practitioner To the cause (s) and manner stated continuing Nurse Practitioner (s) and manner stated continuing Nurse Practitioner (s) and manner stated continuing Nurse Practitioner (s) and manner stated continuing Nurse Practitioner (s) and manner stated continuing Nurse Practitioner (s) and manner stated continuing Nurse Practitioner (s) and manner stated continuing Nurse Practitioner (s) and manner stated continuing Nurse Practitioner (s) and manner stated continuing Nurse Practitioner (s) and manner stated continuing Nurse Practitioner (s) and manner stated continuing Nurse Practitioner (s) and manner stated continuing Nurse Practitioner (s) and manner stated continuing Nurse Practitioner (s) and manner stated continuing Nurse Practitioner (s) and manner stated continuing Nurse Practitioner (s) and manner stated continuing Nurse Practitioner (s) and manner stated conti To the within 2 29b. Signature and title of certifier 29c. License number D5484 12012 raddress of person who completed gause of death (Item 23a) (Type, Print)

TSh Kan Bah (an 500 upperchese pente Dr. Bal AIRMD 0 31. Date filed (Month, Registrar B

DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month)4 Physician/ 2012 NANCY LEE HAEDERER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Baltimore Hospita If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours Min (Month, Day, Year) **Director** 213-50-6914 66 1 M 2 X F JULY 11,1945 OHIO Usual Residence of Decedent 10d. Inside City Limits must be notified at 10a. State 10b. County 10c. City, Town or Location Director 28a-f 1 Yes 2 X No PERRY HALL BALTO. MD. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ត់ 23a Funeral USA 21128 8609 JESSICA LANE items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. Ь Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify. "natural", 3 Divorced 4 Divorced WHITE th and Mental Hygiene.
77 is marked other than "natur traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) HaedeRer, Nonc Elementary/Secondary (0-12) College (1-4 or 5+) SELF-EMPLOYED BEAUTICIAN/PHOTOGRAPHER 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ELIZABETH DONALD SCHELLHASE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
800 S. STOKES STREET HAVRE DE GRACE, MD. Department of Health ar Important: If item 27 is any injury or other transons. 800 S. STOKES STREET 21078 SPOUSE JOHN S. BROCENOS 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ■ Burial 2 □ Cremation 3 □ Removal from State 4-21-2012 BALTO. MD. DRUID RIDGE CEM. 4 Donation 5 Other (Specify) SCHIMUNEK FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility NOTTINGHAM, MD. 21236 9705 BELAIR ROAD 23a. Part 1. Enter the dis shock, or heart fall Immediate Cause (Final ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause onch line. Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Physician/Medical Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ✓ No Month Year Pregnant at time of death Day been signed by the a should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? page 2 1 Yes 2 No 25, Was case referred to medical funeral director, 26. Place of Death (Check only one) Certificate: To Be Other: 1 ☐ Yes 2 🗹 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) hours after death. Ineral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 70220 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 Sauge Drive, Baltimore MD 21237 Franklin 31. Date filed (Month, Day, Year) APR 2 0 2012 State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Acie Mae Harless Month Apr 16, 2012 Year 1:45 P M Medical 4c. County of Death
Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Catonsville Charlestown Care Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🗆 M 2 💢 F Days (Month, Day Year) Sep 25, 1921 Months 218.22.4695 WV 90 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland aţ 10c. City. Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified MD **Baltimore** Catonsville 1 🗆 Yes 2 🌠 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 715 Maiden Choice Lane Apt CR312 U.S.A. items 2 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 So No Specify: 'natural", 3 Widowed 4 Divorced Specify Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha homemaker at home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ unknown Page 1 and 2 should be ment of Health and Menta Mary Dove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 5834 Oklahoma Road Eldersburg, MD 21784 Loretta M. Arnold daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Good Shepherd Cemetery Apr 19, 2012 Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) ture of Funeral Serv 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Sater the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ ASCVO disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit Cause (Disease or in that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? detached for Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♠ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) 2No Other: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

"Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) ann M. Buttoworth cano R082382 4-16-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ann Butterworth, CRNP 709 maidenthe a cene Balto, ind 21228 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 12386 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kathleen Inman Month 5:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Richey Hospice Baltimore 8. Date of Birth (Month, Day, Year) Jun 15, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours Min 46 **Director** 213-88-2773 1 🗆 M 2 🗶 F 1965 DC Usual Residence of Deceden or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Prince Georges Laurel 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 501 Main st. Apt. 20707 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12 should be filed within 72 hours and alth and Mental Hygiene.
A 27 is marked other than "natural", o þ 1X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: 3 🗆 Widowed 4 🗆 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Edward Inman Georgette Claerhout 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other trai once. Kenny Inman /Son 3 Kinsman View Cir. Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Beltsville, Maryland Chesapeake Crematory 2012 21. Signature of Funeral Service License 22. Name and Address of Family Funeral Alternatives Reloc Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a conse uence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Box Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death signed by the Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Inman performed' certificate 2 🗆 No Yes 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COSINTBIAN 31. Date filed (Month, Day, Year 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 9:15 M Norman Harwood Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Catonsville Baltimore Renaissance Gardens Charlestown Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland Months Days Hours Min Nov. 19 Year 1918 1 🗶 M 2 🗆 F 93 Director 218-03-8210 Usual Residence of Decedent 28a-f show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 XNo Baltimore Catonsville Maryland 10f. Zip Code 10e. Street and Number ō 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be with 1 Funeral 21228 719 Maiden Choice Lane - HR405 USA hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?

1 X Yes 2 No If Yes, Give 1941 Black, White, etc. 1 Never Married 2 X Married ð Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. -1945Specify: White Completed 3 Widowed 4 Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Chief Design Engineer Packing Machinery Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) မ Norman H. Jones, Sr. Myrtle Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Hedley A. Clark, Attorney 711 W. 40th Street, Suite 204, Baltimore, MD 21211 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 04/19/12 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K 22. Name and Address of Facility Cremation Society of Maryland Taylor 23a. Part 1. Enter the disease, or complication 299 Frederick Road, Baltimore, Maryland 21228 s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one Immediate Cause (Final Metastatie Onset and Death Ph_sician/ Squamors disease or condition -Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a nonsequence ory if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) nding physician use as the burial Physician/Medical Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for 5 Other (specify) Month Day Year Pregnant at time of death the P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed' certificate 2 🗆 No 1 Yes 2 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🔀 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending n 24 hours after death.

e Funeral Director: Ai bleted filled in by the fu 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 _ _ 3 _ within 2

To the F 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) (20 MP rson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe laider Choice LN. 2/226 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ David E. Jeffers Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis-Loch Raven Parkville Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 8. Date of Birth Social Security Numbe . Age (In vrs. last birthday) Funeral Year) 938 Days 1 XM 2 □ F Months Hours Min Oct. 16, 219-34-7086 73 Director Joppa Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director MD Baltimore Parkville 1 ☐ Yes 2 🛣 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 United States 8525 Oakleigh Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married δ 1 Yes 2 XNo Specify: Specify: White 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County Highway Worker 11 e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other or other traumatic event, th Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alvertia Marie Moxley Elwood Crawford Jeffers 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Ruth Jeffers-Wife Oakleigh Road Parkville, MD 21234 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 20, Page 1 1 XBurial 2 Cremation 3 Removal from State Bel Air Memorial Bel Air, MD 4 Donation 5 Other (Specify) 2012 Gardens . Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Harford Road, Parkville, 21234 8800 2 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ discase or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death Yes 2 No the detached 9 Unknown P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed k þ Division of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an has autopsy prior to completion of cause of Yes 2 X No 1 ☐ Yes 2√ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica å 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{Yes} \) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 ሺ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work 1 Yes 2 No M Accident Investigation 6 Could not be ☐ Accider
☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who complete UU 31. Date filed (Month, Day, Year) gistrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 12389 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day Mary Louise Johnson April 2012 7:45P Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 124 W. Franklin street Apt.217 Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Hours (Month, Day, Year) Country) South 216-12-0802 88 **Director** 1 □ M 2 🛂 F Sept.23 192B Carolina or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits rector Maryland Baltimore 1 X Yes 2 No Ö 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? than "natural", or items 23a o with 1 Funera 124 W.Franklin St.Apt.217 21201 HZI death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2X No Specify. Specify: Black Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working d 2 should be filed within 7 alth and Mental Hygiene.
127 is marked other than it traumatic event, the Me life. DO NOT use retired) within 7 Elementary/Secondary (0-12) College (1-4 or 5+) Housewife 6th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Norris Mable Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important. If item 27 is any injury or other traionce. Teresa Johnson Harris/daug 3511 Foxcliff CT.Randallstown, MD. 21133 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 04-23-12 Owings Mill,MD Garrison Forest 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, MD. 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. et and Death Immediate Cause (Final (arana Physician. disease or condition Medical resulting in death) Due to (or as a consequence 4mon4 **Examiner** Esquentiary list echoitions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month Month Day Year Pregnant at time of death signed by the at the detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobace use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed 2 No 1 🗌 Yes Division of Vital or Attending Physician: funeral director, 25. Was case referred to pedical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 \square Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No 24 hours after death Funeral Director: A Accident the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signat 29c. License number (Item 23a) (Type, Print) State

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Dayon Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death Social Security Number UNK | 6 Social Medical ltimore university of If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) Sex 1 X M 2 □ F Month: Hours Min Director 4**-1-**2012 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be Funeral 21215 3624 Cottage Avenue USA items 2 filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) n "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ð 2 No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: African-American Completed 3 Widowed 4 Divorced er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) n/a 16a. Decedent's Usual Occupation 16b. Kind of Business Industry n/a (Give kind of work done during most of working Na life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Ith and Mental Hygiene 27 is marked other the traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Tahjai S. Smith Dayon S. Jones Sr. Page 1 and 2 should be 1 ment of Health and Menta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 3624 Cottage Avenue, Baltimore, Md 21215 Tahjai S. Smith/Mother Department of Health
Important: If item 2'
any injury or other t 20a. Method of Disposition

1 M Burial 2 Cremation 3 Removal from State
4 Donation 5 Qher (Specify) 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date King Memorial Park 4-19-2012 Woodlawn, MD Sign, tue o Funcral - ide Licentee 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (outs a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of, or Attending Physician; The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FFMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ ō in the past 12 months? Month Year Pregnant at time of death 2 No be detached 9 Unknown 9 🔲 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? After this certificate 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🔲 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director; A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and add (ess of person who completed cause of death (Item 23a) (Type, Print) 54 Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene												
			State Registrar		Cer	tificate of L	Death		Reg. No. 2	112		2391
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		Year	3. Time	
	Medic		Oma Gay Jewell					April	Day '2	012	601	Ам
west	Examin	er	4a. Facility Name (if not institution, give street and Union Memorial Hospit	·		4b. City, Town, or Baltin		h	4c. County	of Death		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.					or Foreign
	Director		226-54-4950 1 □ M 2	j⊧ 71	Yrs.	IVIOIIIIIS Days	Hours Iviiii		1940	Count Vi	rgini	а
	nd now at	_	Usual Residence of Decedent 10a, State 10b. County	10c City	y, Town or Lo	cation			<u> </u>	10	nd Inside	City Limits
	arylar a-f sh fied a	Director			Hanov					"		es 2X No
	or 28	Dir.	Maryland Anne Arundel		папоч	10f. Zip Code			10g. Citizen of V	Vhat Coun		11
	with the 23a cast be	Funeral	7657 Ridge Road			21076			USA		.,.	
	tems	-un-	11 Marital Status 12 Was	Decedent Ever in U.S	S. 13. V	Vas Decedent of Hi	spanic Origin? (S	pecify Yes or No-		e - America		
9	fter d , or i	by	If Vo.	ed Forces? Yes 24 No G. Give	- 1	f Yes, specify Cuba		to Rican, etc.)		k, White, e		
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ylan	ld be fi Menta arked atic ev	입	Lacy Owens				Has	sie Pres	ley			
, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) Hassie L. Jewell - Da	nughter	19b. Mailir 7657	ng Address (Street a Ridge Roa	and Number or Ru ad, Hano	ural Route Number ver, Mar	r, City or Town, S yland 21	tate, Zip C L076	ode)	1
Baltimore,	ge 1 an t of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal	from State	emetery, cren	sition (Name of natory or other plac		Date	20c. Location -	•		1
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Ba	permit. Page 1 s Department of H Important: If Ite any injury or ot once.		21. Sign ture Funeral Service Licensee	S Mu	253 ²²	. Name and Addres	ngton B1	ry L. Ka <u>vd., Elk</u>	ufman F. ridge, N	.H. @ <u>Maryl</u> :	MMP and 2	1075
П			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death on each line.	h. Do not ente	er the mode of dying	g, such as cardia	c or respiratory arr	rest,		Approximation	etween
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ord	v requ	olete						24a. Was		Were autop	sy finding:	s available
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Ζij	Physici this cer ral direc	70 E	examiner? 1 Yes 2 No Hospital:	1 XInpatient 2 □	ER/Outpatier	othe	er: 4 Nursing	Home 5 🗌 Resid	lence 6 🗆 Othe	er (Specify)		
Division of Vital Records,	ding Pt n. After th funera	Certificate:	1 ☑ Natural 5 ☐ Pending	Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work M 1		28d. Describe h	ow injury occurr	ed		
Sio	l or Attending after death. Director: After I in by the fune	rific		Place of Injury - At ho			163 2 110		Street and Number	er or Rural	Route Nun	nber,
Div	ital or us afte ral Dire		4 - Hornicide determined	ouilding, etc. (Specify	r) 			City or Tow	n, State)			
	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To 2 Medical Examiner: On the only one) 3 Certifying Nurse Practif	e basis of examination	n and/or invest	tigation, in my opinic	on, death occurred	at the time, date a	nd place, and due	e to the cau	se(s) and m	nanner stated.
	To the within 2 To the comple		29b. Signature and title of certifier	7		29c. License	number		29d. Date signed			
	}		Aunolline	MD			3894	0	41711			
	A		30. Name and address of person who completed	cause of death (Item	123a) (Type, F	iversity (oking .	Baltimo	re IMD		212	18
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State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Norvel F. Kuhn 6:15 AM April Medical 4a. Facility Name (if not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death **Examiner** Sanctuary At Holy Cross Burtonsville Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Hours (Month, Day, Year) 148-20-1411 **Director** 1 X M 2 □ F 84 Aug 3, 1927 New York Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 😾 No Virginia Loudoun Ashburn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20900 Runnymeade Terrace Apt. 240 20147 USA death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1X Yes 2 \square No1945Black, White, etc. þ 1 Never Married 2X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced 1947 Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) 12College (1-4 or 5+) Pyro Technician Curtis Wright Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph F. Kuhn Mabel Dekends Department of Health and Ment Important: If item 27 is marke any injury or other traumatic of 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith J. Kuhn, Wife 20900 Runnymeade Terrace Apt. 240 Ashburn, VA 20147 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place, 04/19/12 Baltimore, Maryland Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) Cremation Society Of Maryland, 299 Frederick Road Baltimore, Signature of Funeral Service License Thomas Gregor Inc. Maryland 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between NEUMONA Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying Exami burial-transif Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 the 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ğ in the past 12 months? Month Day Year Yes 2 No 1 Yes 2 L 9 Unknown be detached P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of ause of death? 24a. Was an has page 2 autopsy performed certificate 2 No Yes Yes 21 or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 Accident
3 Suicide 2 No Investigation 6 Could not be filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined the Hospital within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npietely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Mi State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Records, P.O. Box 68760 Hospital or Attending Physician: The law Division of Vital 24 hours a

Registrar DHMH 17 Rev 06-2011

State

Medical

29a. Certifier

(Check

only one 29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6: 28 PM Elaine Teresa King 16 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL BACTIMORE AGNES If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Director 216-36-9159 1 □ M 2 🗓 F 72 Yrs. July 29,1939 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No Maryland Baltimore Lansdowne 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 342 Bigley Ave. 21227 United States items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify. 3 X Widowed 4 Divorced Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene, is marked other than Uniform Clothing Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ George Dimeler Mary Fogarty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health a item 27 i Bud King / Son 2040 Grinnalds Ave., Lansdowne, Maryland 21227 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem. Prk, pr. 19,2012 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FAMBROSE FUNERAL HOME OF LANSDOWNE ral Service Licensee 2719 Hammonds Ferry Rd., Lansdowne, Maryland 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEUMONIA Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Week(Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No Box (23d. Date of delivery 3 Ectopic pregnancy Year Day Pregnant at time of death Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the P.O. signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 L No Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral D Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier P25490 APRIL 16, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALI RAMAR, 900 CATON AVE BALTIMORE, MD 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 15, Day 2012 Physician/ Theodore Kobrin 11:20 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6419 Tone Drive Montgomery Bethesda . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Director 046-16-6443 1**X** M 2 □ F 86 May 16, 1925 Connecticut 28a-f show "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6419 Tone Drive 20817 United States death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ş 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 X Divorced Completed WW II Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Foreign Service Officer State Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Harry Kobrin Mary Homick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6419 Tone Drive, Bethesda, Maryland Shirley C. Kotz/Partner Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Aprif 17, Montgomery crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Bethesda, Maryland 4 Donation 5 Other (Specify) 2012 Crematorium, 22, Name and Address of Facility Chevy Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 21. Signature of Funeral Solice Licensee M00198 23a. Part 1 Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final I year Acute Myelogenous Leukemia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial Fibrillation Paroxysmal 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page, this certificate 2 🗌 No Yes 2 K No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 \sum Yes Other: 2 🔀 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D25818 April 16, 2012

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DHMH 17 Rev 06-2011

Registrar

M.D. 5454 Wisconsin Avenue #925, Chevy Chase, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sean M. Dwyer,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month April Physician/ ^{Day} 2012 2:10 РМ Kuzulis 15 Karlis Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital Social Security Number Age (In yrs. last birthday) If Unde 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 - F Months May 30, Year 923 119-26-5548 Latvia Director 88 Usual Residence of Decedent 28a-f show 10b. County 10a State within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20850 United States 402 Hurley Avenue #203 or items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, other traumatic event, the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural", 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Radio/Broadcast Elementary/Seconday (0-12) College (1-4 or 5+) Voice of America Administrator Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 be Anna Boka Paulis Kuzulis Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a 14743 Braemar Crest Way, Darnestown, Maryland 20878 Maris Juberts/Family Rep. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Apri $\overset{ ext{Date}}{1}$ 21. Department of Important: If it any injury or c emetelM&MEtgonetheyplace) ☐ Burial 2 XCremation 3 ☐ Removal from State 2012 Bethesda, Maryland 4 Donation 5 Other (Specify) Crematorium, Inc. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. John the M01360 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat Ph sician/ Congestiv disease or condition Medical resulting in death) Examiner rdiony ODP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this country. been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 은 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated re and title of certifier 29d. Date signed (Month. Day. Year) 2012 16 O, Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 19129 Doctor Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Month April 16, Joseph Andrew Kitzinger 12:58 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital
al Security Number 6. Sex 7. Age (In vrs. lest by Montgomery Rockville 8. Date of Birth (Month, Day, March 5, If Under 1 Year If Under 24 Hrs. **Funeral** . Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 □ F Days Hours Months Min. ^{Year)} 1929 **Director** 209-20-5912 Pennsylvania 83 March Usual Residence of Decedent or 28a-f shov notified at shov 10a, State with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Rockville Maryland Montgomery ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 20852 309 West Edmonston Drive United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Was Decedent Ever III 0.3.

Armed Forces?

1 ☑ Yes 2 ☐ No

If Yes, Give

Year or Dates. 1952–1955 Black, White, etc. ö 1 Never Married 2 XMarried Completed by 21215-0036 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced Specify: White the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) within 72 | Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Education Principal 5+ other traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ည Thomas Benton Lydia Kitzinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st
Department of Health ar
Important: If item 27 is any injury or other 309 West Edmonston Drive, Rockville, Maryland 20852 Beverly B. Kitzinger/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetey crematory or other place)
Montgomery
Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State April 20,2012 Bethesda, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licens Robert A. Pumphrey Funeral Home/Rockville 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition minutes Medical resulting in death) **Examiner** Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence off. attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ ۾ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed

Yes 2 death? After this certificate 1 Yes 2 No 25. Was case referred to medical B 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending injury ours after death.

leral Director; A
filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) 7260 7 Apri 2012 15/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville InD 20150 Peter Chen 9901 Car Dr MN Medical 31. Date filed (Month, Dav. Year State 20 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Physician/ William Frederick Kaiss Apr 13, 2012 7:03 AM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death **Ellicott City** Lighthouse Senior Living at Ellicott City Howard Social Security Number '. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days Hours 212-26-3054 (Month, Day, Year) Dec 13, 1928 MD **Director** 1 🛛 M 2 □ F 28a-f shov Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at gonee. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard **Ellicott City** 1 Yes 2 TNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3614 Courthouse Dr. #1C 21043 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 2/46/ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Ves 2 No 2/16/1951 If Yes, Give Year or Dates. 2/25/1953 Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Industrial Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ **Elmer Cator Kaiss** Helen Sarah Wilkinson Page 1 and 2 should? ment of Health and Mo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Gale Personal Rep. 4637 Roundhill Road Ellicott City, MD 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗌 Burial 2 🖾 Gremation 3 🗀 Removal from State Atlantic Crematory or other place, Atlantic Crematory, LLC Apr 14, 2012 Glen Burnie, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 MOO 53 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an **Director**: After this certificate has d in by the funeral director, page 2 2 \square No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Assik Ling 2 No 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Controlling Nature Prantition or To the controlling movining death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Contrying Nurse Prantitioner: To the best of my included 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) Hor:1 13 2012 s of person who completed cause of death (Item 23a) (Type, Print) (edu 6334 Lavo (42115 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. mend #1 Per PHY G926 4/20/2012 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Ilya Leybovich Kutsak Physician/ Month :19 PMM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE@NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** 216-37-2182 Director 1 🌠 M 2 🗆 F 86 02/23/1926 UKRAINE Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked outher than "natural", or items 5as or 28a-f sho amportant: If item 27 is marked outher than "natural", or items 5as or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE OWINGS MILLS 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? Funeral 104 PLEASANT RIDGE DRIVE, #224 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Yes 2 X No Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) MEDICAL EQUIPMENT METAL FABRICATOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ LEYB KUTSAK SARA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12109 LONG LAKE DRIVE, OWINGS MILLS, MD 21117 ELENA GUZOVSKY/GRANDDAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM. 04/15/2012 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MĎ 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiomyopalhy End-Stage disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to for as a consequence of Hospital or Attending Physician; The law requires that the death certificate be executed 4 hours after death. Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 □ Nursing Home 5 □ Residence 6 ☐ Other (Specify) Hospital 1 ☐ Yes 2 ☐ No Other: ျာ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MS RajapatheMD DOOS 7465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Baltimore NS RUJAPAKSEMD 2835 SMITH AV 5203 21209

Registrar

DHMH 17 Rev 06-2011

State

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Funeral	٩	Holy Cro 5. Social Security N	oss Host	pital 6. Sex	7. Age	e (In yrs. la	ast birthday)		rer S er 1 Year	pring If Under		8. Date of Bi	rth	<u>Montgo</u> T		y place (State c	or Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's N			. 10							al Route Numb ad Fult					
and 2 Health tem 2 other t	- 1	Karen R. 20a. Method of Dis		daugiite		20b. F	Place of Dispo	osition (Na	me of			Date	· ·	Location - 0			
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Medical Examiner		resulting in death)	Oli	Due to	o (or as a	a consequ	uence of):								\top	ycarb	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transli	Medical	(Check	2 Medical E	Physician: To the Examiner: On the b Nurse Practition	asis of e	xaminatio	n and/or inves	stigation, in	my opinio	on, death o	ccurred a	t the time, date	and pla	ice, and due t	to the ca	iuse(s) and ma	ınner stated
To the withing to the complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete		29b. Signature and			^		MO	29	c. License	number			29d. [Date signed		Day, Year)	012
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #208tale of Maryland /1/20/2012 Jh Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 13, 2012 **Physician** Nellie Margherita Leyh 12:00 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Baltimore 3103 Pinewood Avenue 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year) April 8, 1924 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min, 1 M 2 St F Maryland 88 215-12-5831 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f show the Medical Evaruiner must be notified at 10d. Inside City Limits Baltimore N/A MD Director X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 3103 Pinewood Avenue Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2X No white Specify: ģ Specify: 3 XWidowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, II. Mode once. (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Crossing Guard 12 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Blanche Overcast George Edgar Du Vall ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1103 Little Magothy View-Annapolis, Maryland 21409 Milton Corkran, III-son 20b. Place of Disposition (Name of cemetery, crematory of other place)
Evans Funeral Chapel and Cremation-Belair 20a. Method of Disposition 20c. Location - City or Town, State 4/19/2012 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SCU disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Completed 1 ☐ Yes 2 📉 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No

Hospital or Attending Physician; The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760. attending physician the signed by has certificate this After Director:

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the Funeral Dire To the I within 2

> State Registrar

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

3 Suicide

29a. Certifier

4 Homicide

ONE) KICRNP

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29b. Signature and title of certifier

DHMH 17 Rev 1/2001

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Barbara Ann Lawson 09:15 AM APRIL 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Director 218-44-4207 68 1 🗆 M 2 🔀 F 12-11-43 Wash.D.C. 10b. County 10c. City, Town or Location death with the Maryland Director r 28a-f s notified Maryland Baltimore 1 Yes 2 ☐ No or 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a or dical Examiner must be r 21215 3303 W.Northern Parkway USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) K Mart Elementary/Secondary (0-12) College (1-4 or 5+) Sales Person 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harold Tillie Viola Brown or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sidney Lawson/Husband 3303 W.Northern Pkwy.Baltimore, Md. 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 04-21-12 Woodlawn, Maryland 4 Donation 5 Other (Specify) Woodlawn Cemetery 21. Signa re Funeral Service Licens 22. Name and Address of FacilityChatman-Harris Funeral Home 5240 Reisterstown Rd.Baltimore, Md. 21215 u 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Hepatic encephalopathy disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Metastatic colorectal cancer Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). burial-transi Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ page 2 should be detached for in the past 12 months?
1 ☐ Yes 2 🗶 No Month Pregnant at time of death Day Year 1 ☐ Yes 2 ₽ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performe 1 🗌 Yes 2 🗌 No 1 ☐ Yes 2 🗙 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Tyes 2 X No Other: ြုင 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ★Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) P26514 Calin, MD April, 15, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAL HOSPITAL OF BALTIMORE, 2401 W. BELVEDERE VIVEK KALIA, M.D. AVENUE, BALTIMORE, MD 21215 31. Date filed (Month, Day, Year) 32. Rogistrar's Signatur State APR 2 0 2012

DHMH 17 Rev 06-2011

Registrar

BARA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Irvin Michael Lowdermilk 3 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charles LaPlata Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day, Year)
[an 16,1954] 1 M 2 □ F Days Months Hours Min. **Director** 215-60-7820 Pennsylvania 58 Jan. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified MD St. Mary's Lexington Park 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19818 Tippett Road 20653 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black. White, etc. õ 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 X No 1 ☐ Yes 2X No Specify: "natural", Specify: White 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Transportation Be 17. Father's Name (First, Middle, Last) Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) James Edward Lowdermilk Myrna Lorraine Corbett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Pitts / sister 25946 Timothy Court Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place. 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 4/20/12 Woodbine, MD 21. Signature of uneral Service Licensee Going Home Cremation Service P.O. Box 784 el M01651 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran the attending physician and that initiated events resulting in death) Last Due to (or as a consequence-f) Physician/Medical MOn Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 g Unknown n signed by tl Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 2 🗎 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No funeral director, B 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural iniury 5 Pending work? 2 🗆 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the post of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the ways of examplation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the Certifying Nurse Praction nation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check s of exa only one) 3 🗌 To the b 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20600 filed (Month, Day, Year) 32. Registrar's State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Evelyn Landis Lackey Medical April 2012 18 10:35 AM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Gaithersburg Montgomery Social Security Numbe If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 □ M 2**XX** Hours Min. **Director** 155-01-5461 Country) Yrs. 94 Feb. 6, Pennsylvania Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery 1 😾 Yes 2 🗆 No Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Russell Avenue, Apt. 215 20877 USA 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Prince George's Elementary/Seconday (0-12) College (1-4 or 5+) 12th 5+ County School System Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leidy M. Landis B. Naomi Leatherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas L. Lackey/Son 6508 Lisa Lane, Bowie, MD 20720 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk 4/23/2012 Elkridge, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, 313 Talbott Avenue, Laurel, MD M01103 23a. Part 1 Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Spil Ph sician/ allor disease or condition Medical resulting in death) Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 this certificate has autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 Division of Vital director 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No ဂ္ Other: 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of Crtific Pate signed (Month, Day, Year)

State Registrar 30. Name and address of perso

31. Date filed (Month, Day, Year)

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1203301

(3 31 therobur

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

12-02915 Kevin Larson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1- For State Certific Registrar	cate of Death	Reg. No. 20	12 1241
Media	Physic al Exam		_		2. Date of Death Month Day Year April 14, 2012	3. Time of Death
7.			4a. Facility Name (if not institution, give street end number)	4b. City, Town, or Location of Dear		
	_		103 Sorrento Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last bi	Baltimore		
	Funeral Director		216-60-5590 1™M 2□F 58	thday) If Under 1 Year If Under 24Hi Months Days Hours Mi	1F0	Birthplece (State or reign Country) Virginia
	any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	Maryland 28a-f show	ō	MD Balti	more		1 XYes 2 No
	eath with the Maryland items 23a or 28a-f shous to be notified at once.	Director	10e. Street and Number 103 Sorrento Avenue	10f. Zip Code 21 229	10g. Citizen of What C USA	ountry?
	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mornell Hygiden Department of Health and Mornell Hygiden "matural", or items 23a or 28a-f she Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other trammatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No	13. Was Decedent of Hispanic Origin? (8 If Yes, specify Cuban, Mexican, Puert	Specify Yes or No- o Rican, etc.) 14. Race - An White, etc	nerican Indian, Black,
	irs after	þ	3 Widowed 4 Divorced If Yos, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a.	1 Yes 2 No specify: Decedent's Usual Occupation (Give kind of	work done 16b. Kind of Busines	
36	thin 72 hou te. than "nat edical Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use re		samuasu y
5-0	Hygier other	ပ်	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)	
21215-0036	ld be fi Aental narked event,	o Be	Gustav Adolf Larson 19a. Informant's Name/Relationship (Type, Print) 19	b. Mailing Address (Street and Number or	ne Hope Davis	
MD,	2 shou h and l 27 is r	ြို	i:	23 Silver Run Valley		
<u>ē</u>	f Healt f Healt f item er tra		20a. Method of Disposition 20b. Place	of Disposition (Name of cemetery, tory or other place)	Date 20c. Location - City	
Baltimore,	Page ment o tant:		4 Donation 5 Other Specify: Final	Journey Crematory 0	4/19/12 Woodbine	, MD
Balt	permit Depart Impor injury		21. Strinature of Funeral Service Licensee MO1251	22. Name and Address of Facility Going Home Cremati Beverly L. Heckrot	te. P.A. clarksvi	Box 784 lle, MD 21029
	nysician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
	kaminer		Immediate Cause (Final disease or condition resulting in death) a. Cocaine and alco. Due to (or as a consequence of):	hol Intoxication		Death
		Ļ	Sequentially list conditions, b			
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Box 6876	leath certificate e attending phy for use as the b	Physician/Me	4 Pregnant at time of death	Petal death 3 Ectopic pregnation Other (Specify)	23d. Date of delive ancy Month	Day Year
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s, P.O	uires that t n signed b id be detac	by	rath. Other algumean conduction contributing to death out not resulting	g in the underlying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 No 3 Pr	
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Rec	The ficate f, page				1 Yes 2 No 1 V	
/ital	rsician iis certi director	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/O	26.Place of Death (Check utpatient 3 DOA Other Nursin	only one) ng Home 5 Residence 6 ✔ Oth	er: Scene
of	ing Phy After th uneral		27. Manner of Death 28a. Date of Injury (Month Day Year)	Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	or. 000110
sion	Attend death. ctor: by the f	catio		11:20 am	unknown	
Division	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as the	Certification:	4 Homicide determined (Specify) Reside	rm, street, factory, office building, etc.	28f. Location (Street and Number or F or Town, State) 103 Sort Baltimore, MD.	Rural Route Number, City rento Ave.
7	To the How within 24 h To the Fur completely	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal one) Physician: To the best of my knowledge, deal one) Wedical Examiner: On the basis of examination and/or in			
2	S H & H	Me	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (M	onth, Day, Year)
			In. It	O.C.M.E.	April 15, 2012	
	\$		 Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 90 	0 W. Baltimore Street, Baltimore	, MD 21223	
	S	tate trar	31. Date filed (Month, Day Year) 32. Registrary Signature APR 2 0 2012	41		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mar 2012 9:15 A M 04 Margree Medical 4a. Facility Name of not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Marley Neck Health and Rehab. Glen Burnie Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖵 F Months Hours Min. (Month, Day, 1 **Director** 214-38-408] 76 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaninas must be a start of the start and the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the start of the star 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits 1 🗌 Yes 2 💢 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7852 Roberts Court #9B 21061 S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Completed by | Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 XWidowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th grade na Nurses Aide Muscogee Manor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Susie J. Williams Albert Lerol Burley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3360 Wye Mills South, Md 20724 Irene Bessie Scales-Sister Laurel, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site 4/23/2012 Baltimoe, Md of Jul eral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) nset and Death Physician, ardiac Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending 1 Tes 2 No Accident Investigation after death 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined า 24 hours ล e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifie 29c. License number 9012

State Registrar 30. Name and address of person

Marsha

Elkridge

o completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year Month lud4 IYRRINE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b_City, Town, or Location of Death 4c. County of Death marc If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth
(Month, Day, Ye)
01-27-1 **Funeral** Birthplace (State or Foreign Country) 1 🗆 M 2 🗶 F Months Hours Min Director 313-44-4260 Yrs ENDIANA 1-27-Usual Residence of Deceden or 28a-f show 10a. State items 23a or 28a-f shoner must be notified at 10b. County filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits PORTAGE TN 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 46368 TRUMAN STREET 1860 US. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑No Specify "natural", 3 Widowed 4 Divorced Specify: BLACK Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 l
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Important: If item 27 is marked other than "na
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1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Year signed by the a 9 ☐ Unknown 9 Unknown Part II. **Other significant conditions** contributi*n*g to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed should been : 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has t lirector, page 2 s autopsy performed?
1 Yes 2 No 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Hospital မ 2 V No Other: 1 1 Inpatient ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? I Director: After to in by the funeral 28d. Describe how injury occurred 5 Pending 1 Natural 1 \sum Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and litle of certifier 29d. Date signed (Month, Day, Year) 34359 (OHIO) mil 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven Blud 3900 Date filed (Month, Day, Year) 32. Registrar's Signature

✓ DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ Cecilia Kesel Mullen 2:28 17°, 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore 8 Clipstone Court Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Social Security Number **Funeral** Days Hours 233-52-4237 77 1 M 2 V Director Nov. 11,1933 West Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b Counts at Director or 28a-f sh notified Baltimore Baltimore MD 1 D Yes 2 XNo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö ms 23a or must be r 21236 Funeral 8 Clipstone Court United States 72 hours after death with "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. Yes 2 X No Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3

▼ Widowed 4 □ Divorced Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4 or 5+) 12 Housewife marked other Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Pearl Hower Herbert Bodkin 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 756 Roland Avenue Bel Air, Maryland 21014 Patricia Celozzi-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20a. Method of Disposition 20c. Location - City or Town, State April 24, Department of Important: If it 1 X Burial 2 Cremation 3 Removal from State injury or Parkville, Maryland 2012 4 Donation 5 Other (Specify) Signature of Funeral Service Lice See 22. Name and Address of Facility
Evans Funeral Chapel & Cumation Services 8800 Harford Road Parkville, MD 21234 Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Unmediate Cause (Final Ph. sician/ ADENOCARGNOMA MNCLEAS disease or condition resulting in death) Medical SMONTHS Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 the phy IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) 9 Unknown P.0. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 1+4 PERTENSION 1 Yes 2 6 3 Probably 4 Unknown Division of Vital Records, Completed CHARLE OBSTRUCTUE PSWONTING 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 perform CITAONIL 26. Pla of Death (Check only one) 25. Was case referred to medical To Be 5 Residence 6 Other (Specify) 1 Yes 2 10 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation Director; 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practition (b) the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying Nurse Practitioner 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DU028812 mant/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Vincent A. Dipietro, MD 7801 York Rd. Ste. 102 Towson, Maryland 21204 31. Date filed (Month, Day, Year) APR 2 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10 To The Art of Health and Mental Hygiene 12-02994 Unk Unk State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 16, 2012 2140 hrs Wallace Mabray, III Medical Examiner Ricardo 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 213-11-5466 Country) MD 1 X M 11/24/1985 2 F 26 Usual Residence of Decedent any 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 X Yes 2 No tem 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. MD Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA 2753 Fenwick Ave Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc. 1 Never Married 2 Married Xyes specify: Black If Yes, Give Year or Dates: 3 Widowed 4 Divorced 1 XYes 2 No specify: à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Care provider owne home 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Ricardo Wallace Mabray Jr. Tina Maria Lyle 19a. Informant's Name/Relationship (Type, Print) Mother မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina Maria Lyle 21218 <u>2753 Fenwick Ave Baltimore MD</u> 20a. Method of Disposition UNK 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State √ Ո ⋈ crematory or other place) 1 Burial 2 Cremation 3 Removal from State Baltimore MD Donation 5 Other Specify. 22. Name and Address of Facility Phillip A Weatherford FS PA 21 Signature of Funesal Service License 2431 East Oliver St Baltimore MD 21213 Approximate interval Between Onset and 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Dua to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last ned by the attending physician and detached for use as the burial - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical \mathbf{x} AMENDED #1, per me, \mathbf{g} 926 4-30-12 sm UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ć 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of death? performed? Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other₄ Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other မ 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: FOUND: Subject shot 1 Natural 1 Yes 2 V No 5 Pending Apr 16, 2012 2117 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 Could not be Suicide or Town, State) 1300 Blk. Aisquith Street, Baltimore, MD (Specify) Local Street 4 🗸 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 17, 2012 O.C.M.E Allav 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD State Registra

DHMH 17 Rev 1/2001 OCME 2006

OGME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Ragnhild Gevert Miller Medical 4c. County of Death Facility Name (if not institution, give street and numb 4b. City, Town or Location of Death **Examiner** 3a/timore 0 edal. 9. Birthplace (State or Foreign 5. Social Security Number If Unde If Under 24 Hrs 8. Date of Birth **Funeral** (Month, Day, Year) 338-09-8523 94 Director 1 □ M 2 🛛 F Chicago, Oct.22,1917 ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director MD Baltimore Parkville 1 Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe 21234 United States Funeral 8810 Walther Blvd. Apt. 227 Page 1 and 2 should be filed within 72 hours after death ment of Heath and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) York College College (1-4 or 5+) Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Astrid Fritz Aaron Gevert 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 210 Pine Avenue Severna Park, MD 21146 Debra Lund-Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of April 17, permit. Page 1 a Department of H Important: If ite cemetery, crematory or other place)
Evans Funeral
Chapel – Bel Air 1 Burial 2 XCremation 3 Removal from State Forest Hill, MD 4 Donation 5 Other (Specify) 2012 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Road Parkville, MD 21234 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between ock, or heart failure. List only one cause on pach line Onset and Death Importiate Cause (Final Ph_sician/ 2 day disease or condition resulting in death) dias Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the 9 | Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown The law requires 1 Yes Records. Completed ascular Disease 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed with hibrellation Ventricular 1 Yes 2 No this certificate 1 Yes 2 No Vital 26. Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Vinpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) Division of Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural injury work? 5 Pending 2 No Investigation ☐ Accident within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie uling Zhana D0070605 2012 April Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Date filed (Month, Day, Year

72 hours after death with the Maryland arro Baltimore, Maryland 21215-0036

1 - State Registrar

1. Decedent's Name (First, Middle, Last)

Physician/ Miller Sr. Carroll E. Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Baltimore Washington Med. Center Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year, Feb. 17, Days Director 1 🕅 M 2 □ F 84 1928 Maryland 219-22-1787 28a-f show | Hygiene. | other than "natural", or items 23a or zoes, 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Pasadena Md. Anne Arundel 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral USA 21122 8023 Bellhaven Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black White etc. 1 Never Married 2 Married Yes Yes, Give 2 No 1 ☐ Yes 2 X No Specify White 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) W.R.Grace 12 Packaging Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) id Mental F marked o ည Health and Ment tem 27 is marked other traumatic e Miller Hazel Cooper Elmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7882 Whites Cove Rd. Pasadena, Md. 21122 Carroll Miller Jr. other tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important; If ite any injury or ott once, Burial 2 Cremation 3 Removal from State 4/ 21/12 Donation 5 Other (Specify) Glen Haven Glen Burnie, Md. Cem. 22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 21. Signature of Funeral Servi indications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory article cause on each line. Enter the disease, or co Approximate 23a, Part Part 1. Enter the and and shock, or heart failure. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a con a quence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Other (specify) Pregnant at time of death signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Mann of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending s after death.

I Director: Af ed in by the fu Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral I

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [29d. Date signed (Month, Day, 30. Name and address of person who completed cause of death (Item 23a) (Type Print) WICKS 31. Date filed (Month, Day, Year) 2 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

			For State	State of Maryla		artment of H <i>rtificate of D</i>			giene Reg. No. 20	12 12412
~	Dhysicia		Registrar 1. Decedent's Name (First, Middle, Last)			timoato or b	- Cutii	2. Date of Dea	ath	3. Time of Death
J	Physicia Medic	al	JOSEPH W 4a. Facility Name (if not institution, give str	reet and number)	'H	4b. City, Town, or	Location of Death	APRIL	14, 201	
مرد	Examin	ier	Peaceful Life Adul		ility	Waldo:			1 .	narles
	Funeral Director		5. Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Feb 22	y, Year)	9. Birthplace (State or Foreign Country) South Carolina
	show dat	tor	10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits
	Mary 28a-f notifie	Director	MD Charles	3		Waldorf				1 X Yes 2 □ No
	vith the		1208 Adams St.			10f. Zip Code	602		10g. Citizen of W	hat Country? 1 States
	items	Funeral		Was Decedent Ever in U Armed Forces?		Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-	14. Race	- American Indian,
Baltimore, Maryland 21215-0036	s filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted by	1 ☐ Never Married 2 ☐ Married 3XXWidowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give WW-I Year or Dates.		1 ☐ Yes 2 🔀 No		Tricali, etc./	Specify:	R, White, etc. Black
15-(72 hou n "nat fedica	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	(Give	dent's Usual Occupa kind of work done di O NOT use retired)		king	16b. Kind of Bus	siness/Industry
212	iled within Il Hygiene. other than		Elementary/Secondary (0-12)	College (1-4 or 5+)		mber Hand	ler		Lumber	Mill
and	be filed ental Hy 'ked oth ic event	To Be	17. Father's Name (First, Middle, Last)	1			18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	entanner
aryk	should be fil and Mental 7 is marked or raumatic ev	ľ	James 19a. Informant's Name/Relationship (Type	Murph e, Print)	19b. Maili	ng Address (Street a		al Route Number		ate, Zip Code) 20772
Š	nd 2 sh ealth a m 27 is er trau		Jacqueline Bush /	Daughter						Marlboro, MD
lore	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		20a. Method of Disposition 1 □ Burial 2 🂢 Cremation 3 □ R	emoval from State	cemetery, crei	sition (Name of matory or other place	9)	Date		City or Town, State
ltim	nit. Pagartmer ortant injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses	Ct 10038		ke Cremat				ville, MD
B	Depart Depart Impor any ir	- 1	Stylet rote	man.		Rapp Fune 933 Gist				20910
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	cause on each line.			, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
-6	h sician/ Medical		disease or condition resulting in death)	Due to (or as a consec		FAILUKE				
	Examiner	Ļ	Sequentially list conditions, b.							
	ed	Examiner	if any, leading to immediate cause. Liner Underlying Cause (Disease or injury	Due to (or as a consec	quence of):					-
	execution and ial-tran	Еха	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):					
260	cate be executed physician and s the burial-transit	edical	d							
687	pertificanding properties as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregn	ancy				23d. Date	e of delivery
. Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown		☐ Ectopic pregnancy ☐ Other (specify)	У		Mon	•
, P.O.	v requires that the book to be book to be detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the detailed by the deta	ρ	Part II. Other significant conditions cont	tributing to death but not re	esulting in the t	underlying cause give	en in Part I.			bute to the cause of death? 3 Probably 4 Vunknown
ords	been should	Completed	DEMENTIA					24a. Was a	an 24b. W	/ere autopsy findings available
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of Vi	Physi r this c eral dir	e: 10	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 Inpatient 2 28a. Date of injury	28b. Time of	28c, Injury	4 ☐ Nursing H		ience 6XXOther	
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Division of Vital Records,	al or Attending s after death. Il Director: After ed in by the fune	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At Inbuilding, etc. (Speci		eet, factory, office		28f. Location (S City or Tow		r or Rural Route Number,
_	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check 2 Medical Examine	ian: To the best of my knower: On the basis of examination Practitioner: To the best of	on and/or inves	tigation, in my opinio	n, death occurred a	it the time, date a	nd place, and due	to the cause(s) and manner stated.
_	To the within 2 To the comple	-	29b. Signature and title of certifier			29c. License	-			(Month, Day, Year)
	IVP				ver		010105500	05	APRIL 16	, 2012
	\		30. Name and address of person who cor RAMASWAMY PARTHASA				ST. NG 1	JASHTNO1	ON DC 20	1/122 / 622
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Sign	oturo		- 11ff 3			7.7.7.100
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Michael Vincent Manieri APRTL 18,2012 4:17A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE Social Security Numbe If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 217-68-2222 40 1 X M 2 D F October 2, 1971 Maryland Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sh notified a Maryland Baltimore Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 7602 Knollwood Road 21286 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc þ 1 X Never Married 2 Married Yes Yes, Give 2 X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the Fire Fighter Baltimore City Fire Dept. of Health and Mental Hygi item 27 is marked other other traumatic event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frank V. Manieri Mary C. Wilhelm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank V. Manieri/Father 7602 Knollwood Road Baltimore, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery 4-23-12 Baltimore Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 2. Name and Address of Facility Leonard J. Kuck, Inc. 5305 Harford Road Baltimore Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIO-RESPIRATORY ARREST Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PULMONARY EDEMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of). the burial-transi SEVERE AORTIC INSUFFICIENCY Due to (or as a consequence of): resulting in death) Last Physician/Medical AORTIC VALVE ENDOCARDITIS IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Month Year 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HUMAN IMMUNODEFICIENCY VIRUS 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown LACTIC ACIDOSIS 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed? Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \sum Yes Hospital ျှ 2 No Other: 1 X Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide filled in by the Investigation 6 Could not be 3 ☐ Surcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31826 and 18-12 icum

Box 68760

P.O.

Records,

Division of Vital

Registrar DHMH 17 Rev 06-2011

State

RICHARD LINTHICUM, M.D. 7601 OSLER DRIVE TOWSON, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig ature

31. Date filed (Month, Day, Year)

APR 2 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ APRTL 17,2012 6:00 P.,M HAZEL VIRGINIA MARTIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTO. 10932 RED LION ROAD WHITE MARSH Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days Hours 213-28-9797 80 **Director** 1 🗆 M 2 🔀 JUNE 9,1931 MARYLAND Usual Residence of Decedent show 10a, State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f BALTO. WHITE MARSH 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 10932 RED LION ROAD 21162 USA 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify: 3X Widowed 4 ☐ Divorced WHITE "natural" Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. other than " /Secondary (0-12) College (1-4 or 5+) FORESTRY DEPT. CLERK other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ HELEN LEIGHT WILLIAM PARKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health : DTR. 10932 RED LION ROAD WHITE MARSH, MD.21162 PEGGY CARR 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 4-20-2012 PARKVILLE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD NOTTINGHAM MD. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Physician/ NEUMONIA disease or condition Medical resulting in death) a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate muss. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) signed by the atter d be detached for in the past 12 month 1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 L Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 10 214- disease reace obstructive Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has Fibrois perform Pulmonary Yes 2 1 Tes the funeral director, Be (25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 **X**No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending within 24 hours after death.

To the Funeral Director: After X atural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 10 29b. Signature 10034650 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5009 HONEYGO CENTER DRIVE STE.216 NOTTINGHAM, MD. 21236 J. COOL State APR 20 Registrar

DHMH 17 Rev 06-2011

		For State Registrar	State	of Marylan		artment rtificate			and M		giene Reg. No		12	121.11
Physicia: /Medica		1. Decedent's Name (First, Middle John	McCormi	.ck				-		2. Date of De Month 0 4 / 1	ath Da	y Ye	ear	3. Time of Death 1:47a M
Examine		4a. Facility Name (If not institution 5241 Kramme Av		ımber)		4b. City, Balt		Location o	of Death		4c.	County of I	Death	
Funeral Director		5. Social Security Number 190–32–1563	6. Sex 1XXM 2□ F	7. Age (In yrs. 69	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Date 09/12/	th ly, Year) 1942	9.	Birthpl: Count	ace (State or Foreign ry) PA
Maryland		Usual Residence of Decedent 10a, State 10b, County MD			y, Town or Lo ltimore								10	d. Inside City Limits 1 X Yes 2 □ No
h with the	Funeral Director	10e. Street and Number 5241 Kramme Ave	•	<u> </u>		10f. Zip 2	Code 1225				10g. Cit U	izen of Wha SA	t Count	ry?
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	2	11. Marital Status 1 □ Never Married 2 □ Marr 3 □ Widowed ₩XDivorced	ied Armed F	2□ №196	2-	Was Deced If Yes, spec	city Cuba	ispanic Orion, Mexican	gin? (Spe	ecity Yes or No Rican, etc.))~	14. Race - Black, V	White, e	tc.
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Medical Exam	Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12)		(1-4or 5+)	(Give life. I	dent's Usua kind of wor DO NOT us ch Adi	rk done d se retired	during most ()		ing		ind of Busin		ustry
/land uld be file Mental Hy irked othe	10 126	17. Father's Name (First, Middle, Charles H. McC								(First, Middle McGill		Surname)		
≥ 5€5.5		19a. Informant's Name/Relations Sean McCormick			19b. Mailir 4220	ng Address Ruby 1	(Street i	and Numbe Colo	er or Rura rado	Sprine	er, City o	or Town, Sta	1te, Zip 918	Code)
Baltimore, bermit. Pages 1 ar Department of Hea mportant: if item; any injury or other		20a. Method of Disposition 1 ☐ Burial 2 Cremation 4 ☐ Donation 5 ☐ Other (S			Place of Dispo cemetery, crei Arund	matory or o	ther plac	ory 0)/2012		nton,	-	vn, State
Baltimol permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Service	Licensee	M0145	2 B	Name and ailey 023 A	d Addres Fun nnap	eral olis	Home Rd.,	and C Halet	rema horp	tion S	Serv 212	rice, PA
Sylon, A safe be executed hysician and the burial-transit the burial-transit	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Me Due to	caused the deat each line. (or as a conseq (or as a conseq (or as a conseq	uence of):	er the mode					rrest,			Approximate Interval Between Onset and Death
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uires that signed by id be deta	2	Part II. Other significant condition	ons contributing to	death but not res	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did t				e cause of death?
The law ate has b page 2 sl	Сощрівтва									24a. Was auto perfo 1 Yes		prio dea	r to com th?	sy findings available pletion of cause of
die y	0	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpatien	nt 3□ DO	A Othe			n <i>(Check only o</i> me 5 ☐ Resi		6 □Other (Specify)
on or of ding Phy h. After this funeral d		27. Manner of Death 1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investig		of Injury oth, Day Year)	28b. Time of Injury	f 21	8c. Injun Work		2	28d. Describe				
DIVISION O Ne Hospital or Attending Ph 24 hours after death. Ne Funeral Director: After th oletely filled in by the funeral	Serillica	2 Accident Investig	not be 28e. Plac	e of injury - At ho ling, etc. <i>(Sp</i> ec <i>it</i>	ome, farm, str (y)					28f. Location (City or To			or Rural	Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical		g Physician: To th E xaminer: On the l and mai											
To the within 2. To the complet	M	29b. Signature and title of certifie				290	License	number	78	2	29d. Da	te signed (A	Nonth, E	Pay, Year)
	-	30. Name and address of person	4.4	se of death (Item	n 23a) (Type,	Print)	<u>ر ۱</u> اد ۸	111	70	0 (1	^	N.1	<u>ں</u> 	2012 D20769
State Registra		31. Date filed (Month, Day, Year) APR 2.0 2012	(a KO),	Registar's Signa		1/01/	12 K	0 #	- 22	-8 G/e	<u> </u>	1)a/c	- M	15 20 107

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4 Dorothy Faye Myers 20°12 3:10 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Fox Chase Nursing And Rehabilitaion Center Silver Spring Montgomery Birthplace (State or Foreign County)

exas Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min 1 D M 2 D F 464-20-1902 85 (MO777239/1926 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Yes 2 No MD Montgomery Silver Spring 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2015 East-West Highway 20910 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes No Specify. 3X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Wesley Crow Jessie Alford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce, Sherilynne K. Smith / Daughter 14016 Bardot Street, Rockville, MD 20853 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State emetery, crematory or other place) Chesapeake Crematory 4/17/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licep 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): burial-transi Dementia that initiated events Hospital or Attending Physician; The law requires that the death certificate be exec resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 18 months?
1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page performed? Yes 2 No death? 2 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes X ☐ No <u>۾</u> Other: 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Yes Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 0067092 04.16.2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Weihan Wang, MD, 15245 Shady Grove Road, Rockville, MD 20850.

Registrar

31. Date filed (Month

APR 2 0 2012

James Clark Nye A Positive Number of The equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of the equipment of th			· regional	te of Death	Reg.	No2012 124
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year of the cause) 29d. Date signed (Month, Day, Year of the cause) 29d. Date signed (Month, Day, Year of the cause) 29d. Date signed (Month, Day, Year of the cause)	Attanding Physicial death. ctor: After this certif y the funeral directo		examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DC 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury At home, farm, street, factor	OA Other: 4 Viring Ho 28c. Injury at Work? 1 Yes 2 No	me 5 Residence 28d. Describe how in	njury occurred
30. Name and address of person who completed cause of death (liem 23a) (Type Print)	spital or sours after neral Dire		4 Homicide building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred	at the time, date and place,	and due to the cause	e(s) and manner as stated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	within 24 I	Medic	(Check only 2 Medical Examiner: On the basis of examination and/or investigation one)	c. License number H00612	red at the time, date	and place, and due to the cause(s)
Tracie Ryberg 688 C Poule Road Westminster MD 2115' State 31. Date filed (Apply), Day York 10 32. Registrar's Spnature			Tracie Ryberg 688 c Poole Roa	d Westmi	nster Y	nd 21151

ORIGINAL

larence Nicho		1- For State Registrar	te of Maryland		tment of ficate of		d Mental I		Reg. No.	01	2	1241	
Physic Medical Exam		Decedent's Name (First, Middle, CLARENCE NIC						2. Date of Dea Month April 14,	Day Ye	ar	3. Time of 1306		
		4a. Facility Name (if not institution, University Hospital	give street and number)		1	b. City, Town, or Baltimore	Location of Dea		4c. County		1		
Funeral Director		5. Social Security Number 6	. Sex 7. Ag	e (in yrs. last	birthday) Yrs.	If Under 1 Year Months Days			irth (MM/DD/YYY -1-1980	Foreig	าก	ate or RYLAND	
any .		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Locati	on					10d. Insid	e City Limits	
Maryland 28a-f show i	5	MD. N/A		BAL	TIMOR	E						s 2 No	
Maryl	Director	10e. Street and Number				10f. Zip Code		1	10g. Citizen of W	hat Cour	ntry?		
with the Maryland us 23a or 28a-f sho be notified at ouce,		2328 ARUNAH A	VE . 12. Was Decedent	Ever in U.S.	13. Was	2121 (s Decedent of Hisp		Specify Yes or No	US.		ican Indian,	Black	
ter death ", or iter	by Funeral		1 Yes 2	X No	If Ye	es, specify Cuban,	Mexican, Puert	o Rican, etc.)	Whit	e, etc.		Diagra,	
hours "natur	ted t	 Decedent's Education (Specify Elementary/Secondary (0-12) 	only highest grade com			's Usual Occupations of working life.			16b. Kind of Bu				
5-0036 led within 72 hours af tygiene. other than "natural the Medical Examin	Completed	-10-	-0-	<i>'</i>	DELIVE	ERY ASSIS	STANT		LTOUG	OR P	RODUC	TS	
21215-0036 21215-0036 ould be filed within 7 I Mental Hygiene. I marked other than ic event, the Medica	Be Co	17. Father's Name (First, Middle, La CLARENCE NICHO)	,			1			Maiden Surname				
212 hould be nd Ments is mark	To B	19a. Informant's Name/Relationship		,	19b. Mailing	Address (Street		RAH LEAC Rural Route Nur		n, State	, Zip Code)		
- 연등 등		TIFFARY HOLMES (FRIEND) 21 STONEWAIN CT APT 2A TOWSON, MARYLAND 20a Method of Disposition 20b Place of Disposition (Name of cemetery, Date 20c Location - City or Town, S											
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental important: If item 27 is marked injury or other traumatic event,		1 X Burial 2 Cremation	1 X Burial 2 Cremation 3 Removal from State crematory or other place)										
Baltimo permit. Page Department of Important: injury or ott		4 Dongtion 5 Other Specify: KING MEMORIAL PARK 4-21-2012 BALTIMORE, 21. Signature of Funeral Service Licensee JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME,											
		1721-27 N. MONROE ST. BALTIMORE, MAR 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart											
Physician /Medical		forume. List only one cause on each line. Immediate Cause (Final disease a Multiple Gunshot Wounds											
Examiner		or condition resulting in death)											
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated	Due to (or as a conse	quence of):									
xecuted η and - transit		events resulting in death) Last	Due to (or as a conse	quence of):									
50, te be exectysician an	ledical	UNPENDED	X AMENDED 5 I	er fh	g926	4-23-12	vt						
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funcral Director: After this certificate has been signed by the attending physician and lely filled in by the funeral director, page 2 should be detached for use as the burial - transi	- 21	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live birth 4 Pregnant at t		2 Feta	al death 3	Ectopic pregna	ancy	23d. Date of Month		ay	Year	
O. Bo t the dea by the a	Phys	Part II. Other significant condition	9 Unknown	but not result	ting in the un	derlying cause giv	en in Part I	23e Did to	bacco use contri	hute to t	he cause of	doath?	
F. P.C ires that signed to	d b			Dat Hot Coul	ang ar are dir	donying dadab git	or irri arti.		2 No 3				
ords w requi	Completed							24a. Was a			opsy finding	gs available f cause of	
tal Rec	E S					•		1 Yes		leath? ✔ Yes	2	No	
/ital /sician: nis certif	B	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 🗸 Inpatier	nt 2 ER/	/Outpatient	- 10	ther Nursin		Residence 6	Other:	-		
ing Phy After th	n: To	27. Manner of Death	28a. Date of Injur (Month Day Ye Apr 14, 2012	y 28t	b. Time of Inj				now injury occurre				
Division tal or Attendi rs after death. al Director: A	catio	Natural 5 Pending Accident Investiga	ation		15 hrs		s 2 V No						
Divisior Bospital or Attend 24 hours after death Funeral Director:	Certification:	3 Suicide 6 Could not determine 4 ✔ Homicide	of De		, iarm, street,	factory, office bui	iding, etc.	or Town, St	street and Numbe tate) or Avenue, Ba			mber, City	
To the Host within 24 ho To the Func	Medical C	29a. Certifier 1 Certifying Physicone) 2 Medical Examin	lclan: To the best of my er:On the basis of exam and manner stated.	knowledge, d ination and/o	death occurre	ed at the time, date n, in my opinion, o	and place, and death occurred a	due to the cause t the time, date a	e(s) and manner and place, and d	as stated	d. cause(s)		
6 4 8 4	ž	29b. Signature and title of certifier	O 1	11		29c. License			29d. Date signe		h, Day,Yea	r)	
		30. Name and address of person who	o completed cause of do	ath (Item 22a		O.C.M	.E.		April 15, 20	12			
		Jack Titus MD. Deputy	Chief Medical Ex	•	,	altimore Stree	t, Baltimore	MD 21223					
St Regist		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	ever								
		111-11-00 V											

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Ruffin N	lew	ell, Jr. S 1- For State Registrar	tate of Maryla		artment of ertificate of		and	Menta	l Hy		eg. No.	20	12	124
Physici al Exami		1. Decedent's Name (First, Mide Sterling	_{lle,Last)} Ruffin		Torro 1 1		т			. Date of Dear Month April 15, 2		ar	3. Time o	
		4a. Facility Name (if not institution 130 Whitmoore Terra	on, give street and nu		Newell	4b. City, Tow		cation of D		April 15, 2	4c. County			
Funeral		5. Social Security Number		7. Age (In yrs.	last birthday)	Silver S		If Under 2	24Hrs.	8. Date of Bir	Montgo		tholace (St	tate or
Director		579-46-2423	1XXM 2 F	76	Yrs	Months	Days		Min.		25,1935	Foreig	in `	gton DO
,		Usual Residence of Decedent 10a. State 10b. County		Idon City	, Town or Locati	^^						ı wa		
id how any Ee.	_		ntgomery	Toc. Oils	, rown or Locati		wor	Spri						de City Limits es 2 👿 No
farylar 28a-f s	Director	10e. Street and Number	regomery			10f. Zip Co		SPLI	.ng	10	g. Citizen of W	hat Cour		-21
be filed within 72 hours after death with the Maryland ntal Hygiene. Red other than "natural", or items 23s or 28a-f sho ent, the Medical Examiner must be notified at once.		130 Whitmoor	Terrace			2	2090	1			United	d St	ates	
ath wit items 2 st be n	Funeral	11. Marital Status 1 Never Married 2 XXN	larried Armed Fo			s Decedent of es, specify C				ify Yes or No- can, etc.)		- Ameri	can Indian	, Black,
fter de			/orced If Yes, Give Year	2∐ No 1954–5	6 1	Yes 2XX	No s	specify:			Specify:	Wh	ite	
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2 2 3 4 1	٢	19a. Informant's Name/Relation		/ 0-16	7						ber, City or Tow			
es l and 2 st of Health an If item 27; ther traums		Sterling R. No. 20a Method of Disposition		20b.	Place of Disposi	tion (Name	of cemet	rerra ery,		Silve:	Spring			0901 e
permit. Pages I Department of I Important: If injury or other		1 Burial 2 X Crematio 4 Donation 5 Other S			crematory or oth esapeake		nator	ry o	4/1	9/2012	Belts	svil:	le. M	D
partme		21. Signature of Funeral Service			22. N	ame and Ad	dress of				n Servio			_
왕조르크 ysician		23a. Part I. Enter the disease, o	ser Mo	1544	93:	<u>3 Gist</u>	_ Av e	e., S	ilv.	er Spri	lng,MD	20	0910	mate Interval
Medical (aminer	iner	failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate rause. Enter Underlying Cause.	0 1 10	consequence o	of):									n Onset and Death
be executed sician and urial - transit	al Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence o	of):									
e be ex ysician burial	edical	UNPENDED	AMENDED									_		
e death certificate b the attending physical ted for use as the bu	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in to past 12 months? 1 Yes 2 No 9 Un	ne 1 Live bi	nt at time of de	2 Feta	al death er (S <i>pecify)</i>		Ectopic pre	egnancy	<i>'</i>	23d. Date of Month		ay	Year
gned by t	<u>a</u>	Part II. Other significant condit	lons contributing to	death but not r	esulting in the ur	nderlying cau	use giver	n in Part I.		-	pacco use contri	- torre		of death?
10 the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendently filled in by the funeral director, page 2 should be detached for I	Completed					_			_	24a. Was a autops perform	y p ned? d		mpletion o	ngs available of cause of
certific ector, p	Bec	25. Was case referred to medica examiner?	Hospital:			26.F	_	Death (Che						
Fhysicar this and dir	욘	1 Yes 2 No 27. Manner of Death	28a. Date o	patient 2	ER/Outpatient 28b. Time of In		Injury at	Nu			Residence 6		Scene	
Attending Fh. death. ctor: After ti	ţi	1 Natural 5 Pen	ing FOUND:	Day,Year)	FOUND:	· 1 .		2 ✓ No	len	bject shot		s u		
pital or Attend ours after death. eral Director: filled in by the	Certification:	3 Suicide 6 Cou	d not be mined (Specify)	of Injury - At he	1234 hrs ome, farm, street	, factory, offi	ice build	ing, etc.		or Town, Sta	reet and Numberate) Terrace, Silv			umber, City
10 the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C		nysician: To the best miner:On the basis of	examination a										
To wit	Mec	29b. Signature and title of certific	and manner sta				cense nu			· · · · · · · · · · · · · · · · · · ·	29d. Date signe			ar)
100		and a				0	.C.M.E	.			April 16, 20			
1		30. Name and address of person Ling Li, MD Assista	who completed cause		•	Street, E	Baltimo	ore, MD	2122	1 3				
		31. Date filed (Month, Day Year)		istra's Signa										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State Registrar 27 State of Maryland (Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4/6/2012 Day Physician/ seam 1000C 5:45pm M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3445 Yellow Bank Road Dunkirk Calvert 6. Sex 9. Birthplace (State or Foreign Country) Indiana 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 315-64-9210 Funeral Months Days Hours Min 7/7/1961 50 **Director** 1 □ M 2**X**CXF or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director MD Calvert Dunkirk 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be n Funeral 3445 Yellow Bank Road 20754 USA er than "natural", or items the Medical Examiner mus 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White Armed Forces? 1 Never Married Married by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Specify. 3 - Widowed 4 - Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ant of Health and Mental Hygiene.

t. If item 27 is marked other than "n, or other traumatic event (Specify only highest grade completed) (Give kind of work done during most of working DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) OB/Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Trippel မ Bokhart Eleanor 19a. Informant's Name/Relationship (Type, Print) **Kevin O'Dell /Husband** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 3445 Yellow Bank Road, Dunkirk MD 20754 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place,
Fairview Cemetery 1 ☐ Burial 2 ☐ Cremation 3 🖺 Removal from State 4/12/2012 Mishawaka, 4 ☐ Donation 5 ☐ Other (Specify) Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 Victor P. Doda Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Photi i n META STATIC MULTIFORME disease or condition GLIOBURSTOMA Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): and burial-tra Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown i signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2. N within 24 hours after death.

To the Funeral Director: After this certificate I 2 No To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Tyes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2012

Registrar

State

PRINCE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#310

DRIVE

HUSPITAL

31. Date filed (Mo

GLYMS A MOODY, MD

20675

FREDERICK, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month O'Day 2012 3:35 PM Marie Martin April 16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Hillwood Nursing Center 8. Date of Birth (Month, Day, Year) March 25, 1 Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Months Days Min. Hours 78 **Director** 1934 026-26-1834 Massachusetts March Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 Yes XX No Palm Beach Delray Beach 10e. Street and Number 10g. Citizen of What Country? Funeral be filed within 72 hours after death with 33446 United States 7812 Mansfield Hollow Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. Yes 2 X No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give White Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) the Hospital Dietician other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H 2 Martin Joseph Μ. Margaret С. Flynn Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Pamela O'Day / Daughter 7812 Mansfield Hollow Rd., Delray Beach, FL Department of Healtl Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1XXBurial 2 Cremation 3 Removal from State St. Patrick's Cem. 104/20/2012 4 Donation 5 Other (Specify) Fall River, MA Si atur f funeral Service Licensee Rapp Funeral and Cremation Services DE 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CONGESTIVE HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** MYOCARDIAL INFARCTION Sequentially list conditions, Examine Due to (or as a consequence on if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit CORONARY ARTERY DISEASE and Due to (or as a consequence of) resulting in death) Last • Hospital or Attending Physician: The law requires that the death certificate be £ 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicial eted filled in by the funeral director, page 2 should be detached for use as the buri Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Live Birth 2 Pregnant at time of death Ectopic pregnancy in the past 12 months?

1 Yes 2XXNo Month Year 5 Other (specify) Day 1 ☐ Yes 24 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4XXUnknown DYSPHAGIA, DEMENTIA 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autop. performed: death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) ASSISTED 욘 1 🗌 Yes 2XXNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6XXOther (Specify) LIVING 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 XXcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours aft

To the Funeral Di

completed filled in မ

(Check

only one

29b. Signature and title of certifie

8218 WISCONSIN AVE. #305, BETHESDA, MD SUSAN J. MILLER M.D., 31. Date filed (Month, Day, Year) APR 2 0 2012 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D35579

29d. Date signed (Month,

20814

2012

29c. License number

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

			For	State of Ma	ırylanc				d Mental Hy	giene		
			State Registrar			Cer	tificate of D	eath		Reg. No. 2	112	12422
	Physicia	n/	Decedent's Name (First, Middle, L	,					2. Date of De Month		Year	3. Time of Death
16.è.	Medic	al	Louis	Martin		Orer	berg		April	16, 20		11:45 A ^M
,	Examin	er	4a. Facility Name (if not institution, garage Casey House	ve street and number)			4b. City, Town, or	ville	eath	4c. County	ery	
1	Funeral		•	Sex 7. Age	(In yrs. las	it birthday)	If Under 1 Year	If Under 24 F		rth	9. Birthpl	ace (State or Foreign
	Director		160-14-4635	1 X M 2 □ F	94	Yrs.	Months Days	Hours M	lin. (Month, Da	ay, Year) 26,1918	Penn	sylvania
	d woi	_	Usual Residence of Decedent 10a, State 10b, County		10c City	Town or Loc	ation		100.	20,1310		d. Inside City Limits
	ırylan a-f sh iied a	Director		gomery	TOC. Oity,	IOWIT OF LOC		ersburg	7			1 ☐ Yes 2XXNo
	or 28;		10e. Street and Number	,Omery			10f. Zip Code	ELSDULE	-	10g. Citizen of	What Count	
	with t	Funeral	11537 Sullnick	Wav				20878		Unite	d Sta	tes
	leath items ier mi	Fun	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. V		spanic Origin?	(Specify Yes or No-	14. Rac	e - America	n Indian,
36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	lby	1 Never Married 2 Married	1 Tes 2 X N	10		Yes 2 No		orto radan, oto.,	Specify	ck, White, et	hite
8	ours atura	Completed	3 XWidowed 4 ☐ Divorced 15. Decedent's	Year or Dates.			ent's Usual Occupa				**	
21215-0036	n 72 h i. an "n Medi	dw	(Specify only highest Elementary/Secondary (0-12)		,	(Give k	ind of work done do NOT use retired)		working	16b. Kind of B	usiness/ind	astry
7	withii giene rer th t, the		8	College (1 4 of of	<u></u>	Sa	1esman			Furnit	ure	
Maryland	be filed ental Hyg rked oth ic event	To Be	17. Father's Name (First, Middle, Las	•	1				Name (First, Middle			
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\mathbf{Z}	and 2 should be fil Health and Mental tem 27 is marked (ther traumatic even		19a. Informant's Name/Relationship Natalie Alter		- 1				Blufton,		State, Zip Co 910	ode)
ē,	I and f Heal item (20a. Method of Disposition	<u> </u>		ace of Dispos	sition (Name of		Date	20c. Location		vn, State
E O	Page nent o ant: If ury or		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	Removal from State			atory or other place shington	·	04/19/12	 Adel	phi,	MD
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	nsee					l Cremati Silver Sp		<u> </u>	
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P.O. Box 687	death certificate be executed he attending physician and led for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						23d. Da	te of deliver	v
30X	death e atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at t			Other (specify)	/				Day Year
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<u>o</u> .	requires that the des been signed by the s should be detached	by	Part II. Other significant conditions	contributing to death but	t not resul	iting in the ui	nderlying cause give	en in Part I.		tobacco use cont		ably 4 X Unknown
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of	ig Phi ter thi neral		27. Manner of Death 1 🕅 Natural 5 🗌 Pending	28a. Date of injury (Month, Day,	/ 2	28b. Time of injury	28c. Injury work?	at		how injury occurr		
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by it completely filled in by the funeral director, page 2 should be detach	Certificate:	4 Homicide determine		y - At horr (Specify)	ne, farm, stre	et, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rural F	Route Number,
Ω	spital		29a. Certifier 1XXCertifying Pl	hysician: To the best of m	ny knowle	dge, death o	ccurred at the time,	, date and place	ce, and due to the c	ause(s) and manr	ner as stated	1.
	n 24 h	Medical	(Check 2 Medical Exa	miner: On the basis of exa urse Practitioner: To the	amination a	and/or invest	gation, in my opinior	n, death occurr	ed at the time, date	and place, and du-	e to the caus	se(s) and manner stated.
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	1811		30. Name and address of person wh								050	
	Stat	Α.	GEOFFREY COLMAN 31. Date filed (Month, Day, Year)	M.D., 135	5 PI	CCARD	DR. #100	J, ROCK	WILLE, M	ט 20	850	
	Registra		APR 2 0 2012	Server 32. Registry	190	W.						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:30 PM 201 Franklin D. Osborne April 16, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Hospital Harford Bel Air 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Months Days Hours Min. Country) Virginia 1 M 2 🗆 F 78 Director Nov 10, 1933 226-40-3796 Yrs. Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County Director 1 Yes 2 No MD Harford Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21085 United States 1111 Hollingsworth Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. , or 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: 3 Widowed 4 Divorced "natural", White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Assembler General Motors Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Byrd Unk permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic ence. Unk Osborne injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene Osborne /Niece 939 Oakleigh Beach Rd. Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Apr 18 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Chesapeake Crematory 22. Name and Address of Facility Signature of Funeral Service Licensee MO1585 Polo Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Infaction Immediate Cause (Final Physician. cobable disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b, Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed To Be 25. Was case referred to medical 26. Place of Death (Check only one) of Vital examiner? 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Hurse Practitioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of ce wife 29d. Date signed (Month, Day, Year) 0057221 rson who complete cause of death (Item 23a) (Type, Print) 500 upper Chesapeake Da, Bel Air MA MIN ccueto

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day,

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JSbokne,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 2012 ar 10:25 PM V. 16^{ay} Onorato Marv Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 4300 Cardwell Avenue Nottingham Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Min 577-28-3749 **Director** 1 🗆 M 2 🛛 F 1924 88 Jan. 31, Virginia Usual Residence of Deceden 28a-f show 10a. State the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 💢 No Md.Baltimore Nottingham 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 4300 Cardwell Avenue Apt. 21236 USA "natural", or items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Gi Specify: 3 X Widowed 4 Divorced Completed White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည Virginia O'Leary Urquhart Ernest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard A. Onorato/Son 2 Ruxton Green Ct. Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Parkwood Cemetery 4/24/12 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Signature of Funeral Service Licens once. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or conshock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between
Onset and Death one cause on each line Immediate Cause (Final taa Pancreatic Physician/ disease or condition Medical resulting in death) Due to (or as a conse v ence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events southing in death). Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed g physician and as the burial-to Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 as attending IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Dav 5 Other (specify) Pregnant at time of death 1 Yes 2 4 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the director, page 2 s autopsy performed? Yes 2. To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manper of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of cortifier 29d. Date signed (Month, Day, Year) 054 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print AShKan -Bahran i MD APR 2 0 2012 State

DHMH 17 Rev 06-2011

Registrar

State of Maryland / Department of Health and Mental Hygiene											10101			
			Registrar	(+-4)		Cer	tificate of L	Death			Reg. No.	201	2	1242
	Physicia	n/	Decedent's Name (First, Middle, William	Edwar	a D41	cher				2. Date of Dea Month	onth Day Year			B. Time of Death
	Medic Examin		4a. Facility Name (if not institution,			cher	4b. City, Town, o	r Location of C		April 17, 20 4c. County of				<u>5:45A</u> [™]
	EXAMIN	eı	Baltimore Washi			ter	Glen Bu		Jeau			ne Ar		1
5	Funeral				7. Age (In yrs. las		If Under 1 Year	If Under 24		8. Date of Birt	h	9. B	irthplac	e (State or Foreign
	Director		194-12-9863	1 X M 2 □ F	88	Yrs.	Months Days	Hours N	Min.	(Month, Day 09/17/			ountry)	/lvania
	nd how at	ž	Usual Residence of Decedent 10a. State 10b. County			Town or Loc	eation			05/11/	1723	110		Inside City Limits
	laryla 3a-f s ified	Director	MD Anne A	rundo 1		n Burr								1 Yes 2 🔽 No
	the Nor 28		10e. Street and Number	rundel	GIE	n Dull	10f. Zip Code				10g. Citiz	en of What C	ountry?	?
	s 23a	Funeral	1716 Saunders W	ay							USA			
	death r item ner n		11. Marital Status	Armed For		13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? an, Mexican, P	? (Spec Juerto Fi	ify Yes or No- ican, etc.)	14	4. Race - Am Black, Wh		ndian,
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	d by	1 ☐ Never Married 2 🔀 Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		c / 1	☐ Yes 2 🗓 No	Specify:			S	pecify:		
9	hours natura ical E	lete	15. Deceden		tes.	16a. Deced	ent's Usual Occup	ation			16b. Kin	W n d of Busines	ite s/Indust	rv
218	in 72 e. nan "ı	Completed	(Specify only higher Elementary/Secondary (0-12)	ct grade completed) College (1-	-4 or 5+)	(Give k life, D	kind of work done of NOT use retired)	during most of	workin	g				,
2	filed within 72 at Hygiene. I o ther than ' vent, the Me	a l	12			Cler	ical						e C	ollege
Maryland 21215-0036	be filed ental Hy ked oth ic event	To B	17. Father's Name (First, Middle, Li	ast)				18. Mother's Celia	Name	(First, Middle, i	Maiden Su	ırname)		
Ĕ	should be file and Mental I 7 is marked o raumatic eve		UNKNOWN 19a. Informant's Name/Relationsh	in (Type Print)		don Mailia	- A dalas - (Otas - t			Davida Mussahar	. Oit T	04-4- 3	2 - O - d	
Σg	12 shoulth an 27 is r trau		Bernice J. Pilo		ouse		g Address (Street : Saunders)
Ē,	of Health of Health of Item 27 is		20a. Method of Disposition		20b. Pla	ace of Dispos	sition (Name of		Da	ate		ation - City o		State
m	Page nent c ant: If ury or		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S)		Ciaic		crematory or other place	: A1	göi:	1 19,	Glen	Burni	e, l	MD
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Li	censee	M009	18 Se	Name and Addre	ss of FacilityS	ing	leton F	unera	al & C	rema	ation MD 21061
н			23a. Part 1. Enter the disease, or	complications that c	aused the death.							i Dulli	Ap	proximate
, The land	Physician .		shock, or heart failure. List or Immediate Cause (Final disease or condition		on line.	/ C	h Lery	di	00	25				erval Between set and Death
	Medical		resulting in death)	_ a	or as a conse lud	ce of):	0.0	-					\vdash	_
	Examiner	7	Sequentially list conditions,	b. ———										
	sit sd	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of):								
d_{ξ}	kecute and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseque	nce of):								
0	cate be executed physician and s the burial-transit	dical		d.										
928	ificate ng phy as th		IF FEMALE:											
ق ×	eath certifica attending p	lan/I	23b. Was decedent pregnant in the past 12 months?	1 Live E		death 3	Ectopic pregnand	cy			23	Bd. Date of d	,	
Bo	e deat the at hed fo	Physician/M	1 Yes 2 No 9 Unknown	4 ☐ Pregr 9 ☐ Unkn	nant at time of de own	ath 5 ⊡	Other (specify)					Month	Day	/ Year
Ö.	requires that the der been signed by the a should be detached	/ Ph	Part II. Other significant condition	ns contributing to de	eath but not resul	ting in the ur	nderlying cause giv	ven in Part I.		23e. Did to	bacco use	contribute t	o the ca	ause of death?
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a	ertifice ctor, p	Bec	25. Was case referred to medical examiner?				26. Pl	ace of Death (0	Check o		2 12 110		100	3.140
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n of	Jing F n. After i funer	ate	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		of injury h, Day, Year)	8b. Time of injury	28c. Injun	y at ∴? Yes 2 □ No	- 1	3d. Describe ho	ow injury c	occurred		
Sio	I or Attending Physician: The la after death. Director: After this certificate ha in by the funeral director, page	Certificate:	2 Accident Investig 3 Suicide 6 Could r	ot be	of Injury - At hom	e, farm, stre		res 2 🗆 No		8f. Location (Si	treet and I	Vumber or R	ural Bou	ite Number
Division of Vital Records,	al or A s after Il Dire		4 ☐ Homicide determi	ned buildir	g, etc. (Specify)	, ,	,,			City or Town		varribor or ri	urur rioc	rec rearribol,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitions.	Medical	(Check 2 Medical Ex	Physician: To the be aminer: On the basi	s of examination a	and/or investi	igation, in my opinio	on, death occur	rred at t	ne time, date ar	nd place, a	nd due to the	cause(s	
	To the within To the comple	Σ	only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practitioner:	To the best of my	knowledge,	_	number 6 405			29d. Date	and manner	th, Day,	Year)
			100				100	(-)	C]		`		12	
	10x,		30. Name and address of person w		e of death (Item 2		_	K SOIT	E 11	HEN P		1061		
	Stat		31. Date filed (Month, Day, Year)		egistrar'e-Signatui					1				
	Registra	ir	APR 2 0 2012	know)	d. Aleu	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 19a, b per inf 9926 4-25-12 vt
State of Maryland / Department of Health and Mental Hygiene 20 | 2 12426 amend #7 Per FH G927 4/25/2012 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ Evelyn Jane Porter 4:20 p Medical April 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Renassance Gardens Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) Date of Carlotte, Pay, 1 □ M 2 😿 F Months Days Hours Min. Director 556-18-6770 89 Oct. Utah Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Montgomery MD Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3156 Gracefield Road, Apt.322 20904 USA death 12. Was Decedent Ever in U.S 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than George Washington College (1-4 or 5+) Elementary/Seconday (0-12) Registrar University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lester Columbus Thorne ige 1 and 2 should be nt of Health and Mer t: If item 27 is marke Jennie Bradish Petrie 19a. Informant's Name/Belationship (Type, Print) **Tanner** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith E. Porter/Daughter 447 Strattford Rd. unitA3 Tiverton, RI. 02878 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of h 20c. Location - City or Town, State Date Metro Crematory, Inc. 04/19/2012 1 Burial 2 Cremation 3 Removal from State Important any injury o Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Stephanie Custer 22. Name and Address of Facilit Cremation Society of Marylan, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Week Immediate Cause (Final Physician/ CVA (Cerebral Vascular Accident) disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Atrial Fibrillation 10 years Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death Month Day Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus, Type 2 1 Tes 2 No 3 Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available this certificate has prior to completion of cause of death?

1
Yes 2X No autopsy performed? Yes 2 X No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: မှ 1 🗌 Yes 2 💢 No Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🗶 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c License numbe 29d. Date signed (Month, Day, Year) R1581do 1 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Eileen Gemmell CRPN, 3160 Gracefield Road Silver Spring, Maryland 20904

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 12427 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James Purvis 11th 2012 0900 AM APRIL Medical 4a. Facility Name (if not Institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltimore City EUTAW PLACE Apt 125 Bathmore 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours March 7,1957 214-64-4338 55 1 ₹ M 2 □ F Maryland **Director** Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location Director Maryland Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zin Code 9 10g. Citizen of What Country? items 23a or ner must be r Funeral 1701 Eutaw Place #125 21217 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status and Mental Hygiene.
is marked other than "natural", or iter
aumatic event, the Medical Examiner I Yes, specify Cuban, Mexican, Puerto Rican, etc. Armed Forces? Black White etc by 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Housing Complex Elementary/Secondary (0-12) College (1-4 or 5+) Janitor 11th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Ment. Important: If item 27 is marrinant injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury Lou Jenkins James W. Purvis Sr. Annie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharron Sturdavant/Wife 1007 Orleans Street Baltimore, Md. 21202 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Mt.Carmel Cemetery 04-21-12 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Rd. Baltimore, Maryland 21206 as 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Lardiopulmonary disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** disorder Seizure Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Meninoxiowou

Due to (or as a consequence of): and burial-trar nding physician Physician/Medical certificate be P.O. Box 68760 use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ uncontrolled type Diabetes Records, 2 No 3 Probably 4 Unknown 1 Yes Completed . Were autopsy findings available prior to completion of cause of 24a Was an has autopsy page 2 TZenal Insufficiency After this certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Hospital: Other: 1 🗌 Yes ည ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕽 Residence 6 ☐ Other (Specify) 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural work? 5 Pending iniury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 06-201

Registrar

(Check only one 29b. Signature a

2 0 2012

d title of certi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Schwalber

22

29c. License number

P24423

S. Greene Street Baltimore, MD 21201

29d. Date signed (Month. Dav. Year)

			For	State of M	1aryland / [Department of		Mental Hyg		
			State Registrar	1 4)		Certificate of	Death		eg. No. 2012	1 1 1 1 1 1
	Physicia Medic		Decedent's Name (First, Middle William	F.	Pot	tocko		2. Date of Deat Month April	16, 2012	3. Time of Death 8:50 P M
	Examin		4a. Facility Name (if not institution	give street and number)		4b. City, Town, o	or Location of Deatl	h	4c. County of Death	1
			Potomac Valley				ckville		Montg	
	Funeral Director		5. Social Security Number 090-16-3077	6. Sex 1 X M 2 ☐ F	ge (In yrs. last birti 88	Yrs. Months Days	If Under 24 Hrs Hours Min.		Year) Cou	nplace (State or Foreign ntry) ew York
	A O	,	Usual Residence of Decedent					1200, 12		
	iryland ief sh	Director	10a. State 10b. County MD Mon:	h o o m = 1077	10c. City, Towr		ville			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	he Ma or 28s notif		10e. Street and Number	tgomery		10f. Zip Code	- 		0g. Citizen of What Cou	
	within 72 hours after death with the Maryland ergene er than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at	Funeral	1235 Potomac	Valley Rd.			20850		United St	
	r death or item iner m		11. Marital Status 1 ☐ Never Married 2 🎛 Man	12. Was Decedent Armed Forces	?	13. Was Decedent of I If Yes, specify Cub	lispanic Origin? (Span, Mexican, Puert	pecify Yes or No- to Rican, etc.)	14. Race - Amer Black, White	
903	ırs afte ıral", c I Exam	ed by	3 Widowed 4 Divorced	If Was Give	WW II	1 🗆 Yes 2 🗓 No	Specify:		Specify:	White
15-0	72 hou n "natu ledica	Completed		nt's Education est grade completed)	16a.	Decedent's Usual Occu (Give kind of work done	during most of wor	rking	16b. Kind of Business I	ndustry
72	vithin jiene. or thar the M		Elementary/Seconday (0-12)	College (1-4 or		iife. DO NOT use retired Electrical			Federal Go	vernment
g	be filed v ental Hyg rked othe ic event,	Be	17. Father's Name (First, Middle, L		,		1	me (First, Middle, M		
<u>y</u> la	uld be I Ment narke natic e	오		William	Poto		Mary		Krivdo	
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. To it marked other than "hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		John Potocko /			. Mailing Address (Street 848 Wild Ora				Code) 21029
ore	ge 1 an it of He If iten or oth		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation	3 Removal from Stat	e cemeter	Disposition (Name of ry, crematory or other pla			20c. Location - City or	
를	permit. Page 1 Department of Important: If it any injury or c		4 Donation 5 Other (S	Specify)	Chesa	peake Crema			Beltsvil	le, MD
Ba	Depart Impo		21. Signature of Funeral Service	Human	M 00382	Rapp Fune 933 Gist	cal and C Ave., Sil	Cremation Ver Spri	Services ng, MD 20	910
ı			23a. Part 1. Enter the disease, or shock, or heart failure. List of			ot enter the mode of dyi	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
- 5	hysician/ Medical	š i	Immediate Cause (Final disease or condition resulting in death)	d		MONARY ARRE	ST			Onset and Death
	Examiner				s a consequence of AILURE TO					
	o it	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		DVANCED I					
	ite be executed hysician and the burial-transit	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	C	s a consequence of					
09	s be ey sician buria	dical		L d						
876	tificate ng ph) as the	Med	IF FEMALE:							
Box 687	th cert ttendii	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		су		23d. Date of deli Month	very Day Year
Ö.	he dea y the a ched f	Physician/Me	1 Yes 2 No 9 Unknown	9 Unknown	at time of death	5 Other (specify)			W. C. C. C. C. C. C. C. C. C. C. C. C. C.	
P.O.	that t gned by	by P	Part II. Other significant condition	ons contributing to death	but not resulting i	n the underlying cause g	iven in Part I.		acco use contribute to	
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00 00 00	law re has be je 2 sh	Completed						24a. Was ar autops perforn	y prior to c	opsy findings available ompletion of cause of
ř	sician: The la certificate ha irector, page 2		25. Was case referred to medical			26.5	Place of Death (Che	1 ☐ Yes		2 🗆 No
Vita	/sicia s certi directu	To Be	examiner? 1 ☐ Yes 2 XX No	Hospital:	tient 2 T FR/Ou	7	205		nce 6 Other (Specia	6c)
of	ng Phy fter thii		27. Manner of Death XX Natural 5 Pendir	28a. Date of inj	jury 28b. T	ime of 28c. Inju	ry at	28d. Describe ho		<i>y</i> /
ion	ttendi death, tor: A the fu	Certificate:	2 Accident Investig	gation	Sing. At home to	M 1	Yes 2 No	00(1 1: 0)		
Division of Vital Records,	al or A s after Il Direc d in by		4 Homicide determ		tc. (Specify)	mi, street, factory, office		City or Town	eet and Number or Rura State)	ai Houte Number,
_	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death, within 24 hours after death, for the Funeral Director. After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete	Medical	(Check 2 Medical E	Physician: To the best of the basis of Nurse Practioner: To the	examination and/o	r investigation, in my opin	ion, death occurred	at the time, date and	d place, and due to the c	ause(s) and manner stated.
	To th withir To th comp	-	29b. Signature and title of certifier		,	29c. Licens	se number		9d. Date signed (Month,	
	IN		1/1	-N-		100	9148		4/17/1	2
	10, 1,		30. Name and address of person MARICHU THERE	who completed cause of SA MATAS M	death (Item 23a) (Type, Print) 10 Moveculu	4 R Doz #2	206 Rock	WILLE ME	20852
	Stat Registra		31. Date filed (Month, Day, Year) APR 2 0 2012	32. Regist	trar's Signature	السنا				
			111 11 11 11 11 11	Marie 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Kenneth William Pins April 16, 3:48 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 725 Owens Street Rockville Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1**X** M 2 □ F July 25, 1956 **Director** 482-74-6221 Iowa Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Rockville Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 725 Owens Street 20850 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ed other than "natural", or ite event, the Medical Examiner Black, White, etc. by 1 Never Married 2 XMarried 1 Yes If Yes, Giv Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 4 Journalist Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H 27 is marked of it traumatic ever Anthony Herman Pins Lois Elizabeth Goerdt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberley J. Pins/wife 725 Owens Street Rockville, MD 20850 item 2 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2X Cremation 3 Removal from State Final Journey Crematory 04/21/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Ligen Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Malignant neoplasm of the brain Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Liner University Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): physician sthe burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 X No 1 🗌 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗶 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) After this 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1X Natural 5 Pending work 1 🗌 Yes 2 🗌 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

P.O. Box 68760

Records,

Division of Vital

Jocelyne Kouatchou, M.D. 210 E. University Pkwy. Baltimore, MD 21218 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 0 2012

> Tocelyne Koucitchou, ms

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

D63748

29d. Date signed (Month, Day, Year)

April 16, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Barbara Peny 9:12 AM 2012 Medical APCI 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Season's Hospice Randallstown Baltimore 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 09/14/1940 Days Hours Min. Director 1 - M 2 X F 064-34-5770 71 South Carolina Usual Residence of Decede 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1X Yes 2 No MD **Baltimore** Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 208 Mid Pines Court, Apt. 1B 21117 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces ğ Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed If Yes, Give 3 Widowed 4 Divorced Specify Year or Dates. Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Dennis Gertude Smalls 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nyamakye Peay / Daughter 208 Mid Pines Court, Apt. 1B, Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 4/13/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall alu Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END Stage Multiple Ph sician Scherosis Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Be Completed by Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 month
1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregna5 ☐ Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ျှ Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NS Raj apalle MO 4/11/12 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmore MD 21709. N SRajapaksemo 2835 5milh AV 5203

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND TTEM# IperPHYS# 29d, 8929, 77117 2012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) Michele Janie Parker Michele Jonie Parker 2. Date of Death 3. Time of Death Physician/ Pay AMSPIT 2012 1:25 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5019 36th Avenue Hyattsville Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗀 F Months Day Courtennessee (Mott2/28/1962 103-60-7229 50 Director Usual Residence of Deceder 23a or 28a-f show 10a. State notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD Hyattsville Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Completed by Funeral 5019 36th Avenue 20782 **USA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes Give Specify 3 Divorced 4 Divorced Black Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Financial Liason Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Unkn. Unkn. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Kevin Randolph / Husband 5019 36th Avenue, Hyattsville, MD 20782 20a. Method of Disposition
1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important; If it any injury or o Chesapeake Crematory 4/18/2012 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth, 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No 4 Pregnant a 9 Unknown Month Dav Year Pregnant at time of death 5 Other (specify) ed by the a detached 1 g Unknown n signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has k
completely filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ▼No Be 26. Place of Death (Check only one) 2 No Hospital: Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/2042012 D27521 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOLIS LANHAM, MD 20706 9500 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1 ^{Vea} 12 Audrey Petrusis 6:30 AΜ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Baltimore-Washington Medical Center Glen Burnie 9. Birthplace (State or Foreign If Under 24 Hrs. Social Security Number If Under 1 Year 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) Funeral Days Hours (Month 728 Year) 41 Country) Lithuania 1 □ M 2 🛣 334-32-3959 71 Director Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 1 XYes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 151 Carvel Beach Road 21226 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Race - American Indian. Black, White, etc. ☐ Yes 2 XNo 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🛣 No Yes, Give 3 XWidowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Designer Construction 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Unkn. Halina Bagdonas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 151 Carvel Beach Road, Baltimore, MD 21226 Andrew John Petrusis / Son 20a, Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4/15/2012 Chesapeake Crematory Beltsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the dise shock, or heart failure. List only one cause on each line. 5 V Par Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) [']Examiner Sequentially list conditions, Examine if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran signed by the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregn 3 Ectopic pregnancy 5 Other (specify) in the past 12 mon for Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be Division of Vital Records, 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an has autopsy page 2 performed After this certificate 1 Yes Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) funeral director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 \square Pending 1 Yes 2 🗌 No 24 hours after death. Funeral Director: A: Investigation 6 Could not be Accident completed filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Cartifying Nurse Practioner To the best of my knowledge, sketch at the time, date and place, and due to the within 2 To the I 29d. Daje signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year)

e of death (Item 23a) (Type, Print)

Madisin Park Drive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 19, Day 2012 Norma Linda Procopiow 12:45 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours **Director** 064-26-2071 1 🗆 M 2 🗶 F 80 Oct. 17, 1931 New York Usual Residence of Decedent 28a-f show is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Bethesda 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 7926 Jensen Place United States death 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 X No ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Professor University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Rosario Gigli Emily Cassone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21044 27 Andrea P. Nelson/Daughter 10349 Whitewasher Way, Columbia, Maryland permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) April 27, 2012 20c. Location - City or Town, State 1 🛚 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, Maryland 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc 7557 Wisconsin Avenue, Bethesda, Maryland 20814 Unlhana. 7557 Wisconsin Avenue, Bethesda, M01173 timplul 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one can hs that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PANCREATIC CANCER disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events use as the burial-tran attending physician and Due to (or as a consequence of): resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Year Pregnant at time of death Yes 2 No been signed by the a should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an cate has t autopsy To the Hospital or Attending Physician: The Lawithin 24 hours after death.

To the Funeral Director After this certificate h completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) HOSPICE 1 🗌 Yes 2 **X** No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural work?
1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one) 3 🕱 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature apo title of certifie

12:45

2012

NORMA PROCOPIOW

State Registrar TRACIE L. MORGAN

31. Date filed (Month, Day, Year) APR 2 0 2012

DHMH 17 Rev 06-2011

2300 DULANEY VALLEY RD.

of person who completed cause of death (Item 23a) (Type, Print)

CRNP

29d. Date signed (Month.

MD 21093

TIMONIUM.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 1 2012 3:30 PM Pauline Hestern Puqh Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert Chesapeake Beach 2801 Kilt Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Days Hours **Director** 225-66-1317 1 □ M 2 🖺 F 65 Yrs. 12/01/1946 Virginia Usual Residence of Decedent show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location death with the Maryland Director or 28a-f sl notified 1 🛚 Yes 2 🗆 No Chesapeake Beach MD Calvert 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō must be Funeral 23a 20732 U.S.A. 2801 Kilt Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛛 No If Yes, Give Completed by 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Food Hostess Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked of any injury or other traumatic even once. 2 Kathleen Apple Juanita Whitt Mitchell Reuben 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2801 Kilt Court, Chesapeake Beach, MD 20732 Douglas Pugh / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/17/2012 Hanover, Maryland Anatamy Gifts Registry 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 21. Signature of Funeral Service | censee 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition -IVEA Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 38 IF FEMALE: nse 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy o in the past 12 months? Month Day Pregnant at time of death signed by the a Id be detached f 2 No Yes Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown should Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page 2 performed?

1 Yes 2 No death? 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No М neral Director: A rfilled in by the f ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number April 17,2012 DUD 5906 s of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

30. Name and addre

31. Date filed (Month, Day, Year)

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2012

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32. Régistrar's

Frederick MD 20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Day Month Year 11:09PM **Physician** renkins HOPi /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 M Months Days 215-76-9257 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f shov ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 1 Nes 2 No Funeral Director MD timore 10e. Street and Number 10g. Citizen of What Country? $3a\infty$ 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: Blac Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. po NOT use retired) Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than Name (First, Middle, Majden Surname, Maryland ather's Name (First, Middle Be and Mental ည Injury or other traumatic Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number If item 27 Is Baltimore mD 21207 of Health Baltimore, 20a. Method of Disposition 1 ■ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): ocardia **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): ding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of): gned by the attending physician be detached for use as the buris Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Yes 2 No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 🔀 Inpatient Other: 4 \sum Nursing Home 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ၉ this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division To the Hospital or Attending | within 24 hours after death.

To the Funeral Director: After 1 X Natural 2 ☐ Accident 5 Pending investigation Injury 1 🗌 Yes 2 No 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 ☐ Homicide City or Town, State) 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 16,2012 2E5-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 Govi MO

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and	Mental Hyg		
		1 - State Certificate of Death	F	Reg. No. 201	2 2436
Physicia Medic		1. Decedent's Name (First, Middle, Last) Rose Rost	2. Date of Dea Month	Day 2 OF 7	3. Time of Death 9:15 PAM
Examir		Any Facility Name (if not institution, give street and number) Ab. City, Town, or Location of Deal ON Timore UASSIN: Fer Nedical Center C. E. Bur		4c. County of Dea	ith (A
Funeral		5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) If Under 1 Year If Under 24 Hrs. Min. Months Days Hours Min.		g. Bi	rthplace (State or Foreign
Director		326-10-0819 1 M 2XXF 97 Yrs.	01/24/		IL
faryland Ba-f sho tified at	Funeral Director	10a. State 10b. County 10c. City, Town or Location Millersvil	11e		10d. Inside City Limits 1 ☐ Yes 2XXNo
h the M a or 20	al Dir	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
ath wit	nner	8241 Victoria Road 21108 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Ves or No-		J.S.A.
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Specify Cuban, Mexican, Puerl 1 ☐ Yes 2 ☒ No Specify:	rto Rican, etc.)	14. Race - Am Black, Whi	te, etc.
5-00 hours natura fical E	lete	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business	White
121, thin 72 ane. than " the Med	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)	orking	0	wn Home
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ylar Jan Jan Jan Jan Jan Jan Jan J	우		ine Cipol	.1a	
Maryl 2 should Ith and Me 27 is marl r traumati		19a. Informant's Name/Relationship (Type, Print) Ms. Charlene Ruta / daughter 1314 E. Crabtree Dr:			ts, IL 60004
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", only injury or other traumatic event, the Medical Examone.		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City o	
Baltimo permit. Page Department o Important: If any injury or		4 Donation 5 Other (Specify) Mount Olive 4/	21/2012		, Illinois
Bal permi Depar Impo any ir		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 M01357 Singleton Funeral	-		Burnie, MD
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Physician/ Medical		Immediate Cause (Final disease or condition - OH490NFOP a OH490NFOP			Onset and Death
Examiner		Due to (or as a consequence of): - HYPCMC+it Sequentially list conditions,			
• ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1.765		
execution and and rial-tran	I Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):	- 20812		
date be shysicia	dical	d			
certifica nding p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	elivery
Division of Vital Records, P.O. Box 68/60 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 mg/hths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month	Day Year
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require require been si	eted		1		Probably 4 Inknown
Of Vital Records, og Physician: The law requires ter this certificate has been sig- neral director, page 2 should b	Completed		autops perforr	med? prior to death?	completion of cause of
Ital sician: certific irector,	Be	25. Was case referred to medical examiner? Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital: Hospital:			
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ttendir death. tor: Afr	Certificate:	2 Accident Investigation M 1 Yes 2 No			
DIVISION tal or Attendir rs after death. al Director: After in by the fu		4 Homicide determined determined building, etc. (Specify)	City or Town	reet and Number or Ru , State)	ral Houte Number,
Hospit 24 hour Funers etely filk	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, only one)	d at the time, date an	d place, and due to the	cause(s) and manner stated.
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2		1 / Sech 0005570	73	APRIL 1	8,2012
つり		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAD MON WASH. O'DO MON MON UNITED 31. Date filed (Month, Day, Year)	crim	, our	3 min
Stat Registra	le ar	31. Date filed (Month, Day, Year) APR 2 0 2012 APR 2 0 2012			
		/ W. C			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#18perFH, G926, 4/27/2012, WS
State of Maryland / Department of Health and Mental Hygiene
AMEND ITEM#7perFH, G927, 5/1/2012, WS

Certificate of Death

Reg. No. 2016 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 1145 PM JAMES PATRICK REDDING, SR. 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rosedale Baltimore FRANKLIN Square Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min 91 -92 Director 1 **X** M 2 □ F 215-14-4610 Usual Residence of Decede JUNE 26,1920 PENNSYLVANIA 28a-f show 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MIDDLE RIVER BALTIMORE MD 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral 21220 USA 1330 BURKE ROAD 12. Was Decedent Ever in U.S. Armed Forces?

1 M Yes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 ▼Widowed 4 □ Divorced Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) BALTIMORE CITY CIVIL ENGINEER Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Ahern JOHN MCNAMARA REDDING ANNA CECELIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 GLASSHOUSE GARTH PERRY HALL, MD 21128 MICHAEL REDDING- SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 4/16/2012 BALTIMORE, MARYLAND GARDENS OF FAITH Signature of Funeral Service Licenses 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME 9705 BELAIR ROAD NOTTINGHAM, MD 21236 23a. Pat 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Infacction Physician/ myocardial disease or condition Medical resulting in death) Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed' To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 2 No 1 Yes 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{Other (Specify)} 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [3 [Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practifioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying Nurse P only one) 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) 603374 wx1 30. Name and address leted cause of death (Item 23a) (Type, Print) 9000 FRANKLin Square DR Balto Md 21237 filed (Month, Day, Year) 32. Registrar's Signature State 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death PEESE-CALHOUN Physician/ 910 AM PHILATHIA 2012 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** Randallstown HOSPITAL Baltimore 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month. Dav. Year) 1 🗆 M 2 🏝 F **Director** VA 63 224-68-8122 Jul 15, 1948 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiene 27 is marked Hygiene Important: If tiene 27 is marked than "inatural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director **Baltimore** 1 Yes 2 No **Baltimore City** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21202 U.S.A. 932 North Central Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates **Black** Specify: Completed 3 - Widowed 4 - Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Administration **Girl Scout** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wallena Lawston Lemuel Reese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21202 932 North Central Avenue, William C. Calhoun 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Apr 23, 2012 Glen Allen, Va. Roselawn Memory Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ atten for u in the past 12 months?
1 Yes 2 No Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed' this certificate 2 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ဂ္ ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: / Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗌 29b. Signature and title of certifier 29c. License number April, 16, 2012 D65843

State

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alahallah Kafrouni, 5401 Old Court Road, Randalls town, HD 21133 22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ P24 Frieda Sonia Robinson ABTh 2092 3:45 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6 Seagrave Lane Worcester Rerlin 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Min. (M9013/P24/1930 Coult Paryland 212-50-2427 Director 62 Usual Residence of Decedent show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 □ No MD Worcester Berlin 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 6 Seagrave Lane 21811 **USA** hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmeth. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel Esterson Miriam Goldfein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Robinson / Son 6 Seagrave Lane, Berlin, MD 21811 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State metery, crematory or other place) Chesapeake Crematory 4/18/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ Glioblastoma multifor disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 1 year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> To the Hospital or Attending Physician: The law requires 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 2 No Yes 1 🗌 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 1 Yes 2 🗹 No ျင 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) hours after death.
uneral Director. After the filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 16, 2012 D70053

State Registrar

15

100 East Carroll

31. Date filed (Month. Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stroot

Jacke

Salisbury, Maryland

Division of Vital Records, P.O. Box 68760 within 2 To the I

4/23/

000

IFFE

State Registrar

Medical

6 Could not be

determined

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suicide

4 Homicide

(Check

only one)

Khaiwa

VINAY SHAKMA, MD

31. Date filed (Month, Day, Year)
APR 2 0 2012

106 BOW ST., ELKTON.

32. Registrarts Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D66176.

MD 21921

29c. License number

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 18 12

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 19b, per fh, g26 4-20-12 sm
amend #20bcc Per rh 6927 5702/2012 3Hd Mental Hygiene 20 1 For State Registrar Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2:30A M 4 2012 Medical 4a. Facility Name (if not institution, give street and numb **Examiner** 16 City, Town, or Location of Death County of Death atherine 50 230 AM 1 Year If Under 24 Hrs 6. Sex . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** -1945 Hours Country) 17-60 **Director** 1 M 2 M Usual Residence of Decedent 10b. County death with the Maryland 10a. State City, Town or Location 10c 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code must be r 10g. Citizen of What Country? Funeral USA 21122 12. Was Decedent Ever in U.S. Armed Porces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Blac "natural", Specify. Completed 3 Widowed 4 Divorced Year or Dates of Health and Mental Hygiene.
Item 27 is marked other than "natur other traumatic event, the Medical" 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's N ne (First, Middle, Maiden Surname) မ larren Rich-Peoples 19a. Informant's Name/Relationship (Type, Print) r Rural Route Number, City 19b. Mailing Address (Street and Number or Town, State, Zip Code)MI) Department of Health ar Important: If item 27 is any injury or other trauonce. -07 Method of Disposition 4/27/2012 20cBaltiniore waryland ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Service STUND, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ metas for the ancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury Examine Due to (or as a consequence of) the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery been signed by the atter should be detached for 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year 1 Yes 2 No Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after deatn.

To the Funeral Director. After this certificate has I completely filled in by the funeral director, page 2: Yes 2 No 1 Tyes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2X No Other: 1 Tyes 10 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation M Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 2012 りらろそとし 04,17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Since Mas Date filed (Month, Day, s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 012 Year Apropri RAYMOND 18, 5:50A RUTH DODSON Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 404 Far Hills Court Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 216-03-8091 95 1 □ M 2**X**XF 07/16/1916 Maryland Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2√1 No Maryland | Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a my injury or other traumatic event, the Medical Examiner must be a Funeral 404 Far Hills Court 21286 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify. Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Elementary/Secondary (0-12) life. DO NOT use retired) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Marion Dodson Harriet Boynton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2800 Route 82 Bruce D. Raymond Son Pleasant Valley, New York 12569 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 D Burial 2XX Cremation 3 Removal from State GreenMount Crematory 04/20/2012 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of F Mix Chell-Wielefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ KIDNEY ALLUR disease or condition Medical resulting in death) Examiner HRODIC YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown Part II. **Other** si**gnificant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PERTENSION 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed neec DISEASE Were autopsy findings available prior to completion of cause of 24a. Was an has le 2 autopsy perform page death? 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

29b. Signature and title of certif

104

and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

D0020795

DRIVE

7600 OSEEN

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year BEVERLY RIZIKA 2013 115 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death LEVINDALE HEBREW HOME BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 TTA **Funeral** 1 🗆 M 2 🛛 F Months Days Hours Min Month Pay, Year) 20 Director 91 Yrs. 213-48-6321 Usual Residence of Decedent or 28a-f show 10a. State 10b. County the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMORE PIKESVILLE 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 7 SLADE AVENUE, #821 21208 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ò ģ 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ASSISTANT MEDICAL other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ည **JOSEPH** WEINER MARY KAHN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STUART RIZIKA/HUSBAND SLADE AVENUE, other 1 #821, PIKESVILLE, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl 20c. Location - City or Town, State ARCINGTON CEMETERY CHIZUK AMUNO CONG. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/19/2012 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS.. INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ADVAN CED disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transli Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autops 1 Yes 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tes 2 × No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred the Hospital or Attending work? 1 🗆 Yes 2 🗆 No 1 Natural injury 5 Pending Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tele of certifier 29d. Date signed (Month. Day. Year) 10062895 2012 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) HEBREW GERIATRIC CENTER LEVINDALE NE State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 12444 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Smith 2012 Thelma Medical 04 30a 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore **Examiner** 4b. City, Town, or Location of Death Parkville 1327 Taylor Ave If Under 1 Year If Under 24 Hrs Months Days Hours Min, **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) **Director** 214-26-4708 1 ☐ M 2 🗶 F 11 04 28 MD 83 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location the Maryland 10d. Inside City Limits Director 1 🗆 Yes 2 ื No MD Baltimore Parkville 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a o Funeral 1327 Taylor Ave 21234 U.S.A. items 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ural", or iten 11. Marital Status 14. Race - American Indian. Armed Forc Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give 5-0036 1 ☐ Yes 2X☐ No Specify. "natural" 3 X Widowed 4 Divorced Completed Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 72 alth and Mental Hygiene. 2121 Elementary/Secondary (0-12) College (1-4 or 5+) Bon Secours Hospital Nursing Assistant llth grade Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Grace Sheppard Harry Greene other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1327 Taylor Ave, Baltimore, Md 21228 of Health Beverly Jones-Daughter If item 27 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State ò Department of Important: If any injury or 4 Donation 5 Other (Specify) 4/20/2012 Baltimore, Md On-Site 21. Signature of Fuheral Service L March F/H West Wabash Baltimore, Md 21215 4300 Ave, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) ue to (or as a consequence of Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence or). it any, reading to mimediate cause. Enter Underlying Cause (Disease or injury that initiated events physician and the burial-trans resulting in death) Last Due to (or as a consequence of) attending physician Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ☐ Pregnant at time of death ☐ Unknown 5 Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title completed cause of death (Item 23a) (Type, Print 10 State

✓ DHMH 17 Rev 06-2011

Registrar

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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Genevieve M. Squires 4-19-2012 11:15 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
Wear | Hunder 24 Hrs. Franklin Woods Center Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 □ M 2**)** F Director 235-40-1403 1-22-1915 W/V Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. a or 28a-f show t be notified at 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 2 ☐No Director MD Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a 8620 Sandy Plains Road Completed by Funeral 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 ₩idowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Tin Mill Supervisor Bethlehem Steel permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Venie Nicholson ၉ Opha Heater 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8620 Sandy Plains Road Dundalk , MD 21222 Mary Ellendt Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Maurial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Meadowridge Cem. 4-24-2012 | Elkridge, Maryland 21. Signature of Funeral Se Lice 22. Name and Address of Facility Connelly Funeral Home of Dundalk, MD 7110 Sollers Point Road Dundalk, MD 0 M01176 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIL Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Physician; 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Injury at Work? (Month, Day Year) Hospital or Attending 5 Pending Iniury investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. within 24 the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 4000 ne and address of person who completed cause of death (Item 23a) (Type, Print) FRANKLIN BALTIMURE Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Marylan	d / Depar	tment of He	ealth and	Mental Hy	giene				con
			State Registrar		Certi	ificate of De	eath		Reg. No. 201				4 /
	Physicia	ın/	Decedent's Name (First, Middle, Last					2. Date of Dea	ath Day	Year		. Time of Death	
with	Medic	al	Janet A 4a. Facility Name (if not institution, give s	Sexton				AMONTH	17	201	2	155 P	VI
	Examir	er		aryland Medi		4b. City, Town, or L	1	h	4c.	County of Dea	ath		
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs		 h	9. B	irthplace	e (State or Foreig	חו
	Director			Пм 2 🔀 г 7 3	Yrs.	Months Days	Hours Min.	(Month, Day January		0	ountry)	<i>z</i> ania	
	nd Tow	١	Usual Residence of Decedent 10a. State 10b. County	10c Cib	/, Town or Loca	tion		Strately	20,13	,33 [16]	_		
	arylar a-f sl	Director	Maryland Baltimo		tinghar							Inside City Limit 1 ☐ Yes 2 🔀1	
	or 28 or 28 e not		10e. Street and Number			10f. Zip Code			10a. Citiz	zen of What C	_		_
	s 23a	Funeral	9539 Hickoryhurst	Drive		21236			_	ted St			
	death item	Fur		12. Was Decedent Ever in U.S Armed Forces?		s Decedent of Hisp es, specify Cuban,	panic Origin? (S Mexican, Puert	pecify Yes or No-	$\overline{}$	4. Race - Am	erican Ir		
36	after al", or xami	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced	1 ☐ Yes 2 🛛 No If Yes, Give		Yes 2 X No			s	Black, Whi Spec <i>ify:</i> Wh			
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7	y with ygien her th	e l	12		Cle	erk				ministr		1	
and	e filec ntal H ed ot even	To B	17. Father's Name (First, Middle, Last) George Rebar			1		me <i>(First, Middle, I</i> Iaskulka	Maiden S	urname)			
Maryland 21215-0036	ould b	•	19a. Informant's Name/Relationship (Typ	o Print							_		-
\mathbf{Z}	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Kathleen Sexton (Daugh	111		Address (Street and ckoryhurst)	
re,	1 and of Hee item		20a. Method of Disposition	20b. PI	ace of Disposit	ion (Name of				cation - City o		State	_
Ē	Page nent d ant: If ury or		1 ☐ Burial 2 X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		ns Funera	tory or other place)	el Apri ir 20	1 19 ,	Fore	st Hill,	. Mar	vland	
Baltimore,	permit. Departi Import any inji once.		21. Signature of Funeral Service License	e	22. N	lame and Address	of Facility			-			
ш	<u> </u>		MANITY COL			8800 Harfo	rd Road F	arkville.	Maryl	and 212	34		
			23a. Part 1. Enter the disease, or complishock, or heart failure List only one immediate Cause (Final	cations that caused the death cause on each line.	. Do not enter t	he mode of dying,	such as cardiac	or respiratory arre	est,		Inte	oroximate erval Between	
	h sician/ Medical		disease or condition resulting in death)	Sepsis							Ons	set and Death	
ممييها	Examiner			Due to (or as a conseque	255UL	infe	ntan				7	DAYS	
	_	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque		CITIE	16011					V1193	
	cuted nd transi	Examiner	Cause (Disease or injury that initiated events								77	Da45	
	death certificate be executed ne attending physician and ed for use as the burial-transit	a E	resulting in death) Last	Due to (or as a conseque	ence of):								
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89	certifi nding use a	Σ	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnan					2	3d. Date of de	diver		
Вох	death e atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Fetal 4 Pregnant at time of de		ctopic pregnancy other (specify)				Month	Day	Year	
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<u>ď</u> .	s tha	ا ۾	Part II. Other significant conditions con	tributing to death but not resu	Iting in the und	erlying cause given	in Part I.					use of death?	
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တ္ထ	has b	Completed						24a. Was a autops perfor	SV	24b. Were au prior to death?	itopsy fi comple	ndings available tion of cause of	
ř	sician: The law certificate has k		25. Was case referred to medical			00 51		1 🗆 Yes		1 \(\text{Ye}	s 2	100	- 1
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Division of Vital Records,	ig Phy ter thi neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending		28b. Time of injury	28c. Injury at work?		ome 5 Reside			спу)		\exists
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NSIN	or Att	Certificate:	4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street,	factory, office		28f. Location (St. City or Town		Number or Ru	ral Rout	e Number,	
Ξ	spital ours s eral [29a. Certifier 1 Certifying Physic	ian: To the best of my knowle	dae death eac	urrad at the time of	leto and place	and due to the sec	(2)				-
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director,	Medical	(Check 2 Medical Examine	er: On the basis of examination Practitioner: To the best of my	and/or investiga	tion, in my opinion.	death occurred a	at the time, date an	d place a	ind due to the	cause(s)	and manner sta	.ed.
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			30. Name and address of person who cor		23a) (Type, Print	ene Str.	2-4	2 - 1	00	MT	217	01	
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State of Maryland / Department of Health and Mental Hygiene

Phillip Anthony Scott

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		1- For State Registrar		Certific	cate of	Death			R	teg. No.	. 0 1	Ca Ca 7		
Physic														
Medical Exam	inei								Month April 14, 2	2012	ear	2106 hrs		
		4a. Facility Name (if not institution University Hospital	on, give street and number)		4	b. City, Town, Baltimore		of Death		4c. Count	y of Deati	h		
Funeral		5. Social Security Number	(Y) 9. Bir	rthplace (State or										
Director		212-90-6623	Foreig	on Maryland										
any		Usual Residence of Decedent 10a. State 10b. County		10d. Inside City Limits										
.		Maryland		1 X Yes 2 No										
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with the 18 23a e noti	E	11. Marital Status	6050 Moravia Park Drive Apt. 107 21206 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race-											
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ifter (Il", o	by F	3 Widowed 4 Div	orced If Yes, Give Year or Dates:	140	1	Yes 2X N	lo specify:			Specify	Bla	ıck		
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D 21215-0036 should be filed within 72 hours after death with the Maryland modental Hygiene. 7 is marked other than "matural", or items 23a or 28a-fabonatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) 9th grade	College (1-4 or 5	+) E	_	st of working li ricial		use retired	a) -					
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21215-00; uld be filed with Mental Hygiene marked other t	Ba	Michael A.S					Phyl	lis	Johns	son				
imore, MD 21215-0036 Pages I and 2 should be filed within 7 ment of Health and Mental Hygiene. hant: If item 27 is marked other than or other tranmatic event, the Medica	၉	19a. Informant's Name/Relations		19	b. Mailing	Address (Str	eet and Num	ber or Rur	ral Route Nun	nber, City or To	wn, State	, Zip Code)		
Mark the Same		Shantell Har 20a. Method of Disposition	vey/Sister								_	21220		
Ore, es l a of He If ite			3 Removal from Sta	crema	tory or othe	on (Name of c	· 1		Date	20c. Location	-			
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Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Numature of Funeral Servi	Ucinsee ///		22. Na	me and Addre	ss of Facility	Cha	tman-l	Harris	Fur	neralHome		
		23a. Part I. Enter the disease, or	2	he death. Do no								,MD.21215		
Physician IN-colcat	8 0	failure. List only one cause	on each line.				g, such as ca	il ulac or re	aspiratory arre	est, shock, or ne	eart	Approximate Interval Between Onset and		
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Sox 68 death certifi e attending for use as	ia l	past 12 months?	1 Live birth Pregnant at ti	me of death			Ectopic	pregnancy	У	Month	D	ay Year		
Box 68 e death certif the attending	Physician	1 Yes 2 No 9 Unk	nown 9 Unknown		□ Othe	r (Specify)								
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of Vitaling Physicial	P B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ✓ ER/O	utpatient :	3 DOA	Other ₄	Nursing H	lome 5 .	Residence 6	Other:			
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teath.	읉	Natural 5 Pend 2 Accident Inves	ng Apr 14, 2012	2024	hrs	1	Yes 2 🗸	No Su	bject shot					
Division tall or Attendir rs after death.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or or Town, State)										al Route Number, City		
Spital Cours a nearl 1		4 W Homicide determined (Specify) Local Street or Town, State) 1900 Block Etting Street, Baltimore												
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my liner:On the basis of exami	knowledge, dea nation and/or ir	ath occurred ovestigation	d at the time, d n, in my opinio	late and plac n, death occu	e, and due urred at th	e to the cause e time, date a	e(s) and manner and place, and d	r as stated lue to the	d. cause(s)		
To with	Mec	29b. Signature and title of certifier	and manner stated.			29c. Licens				29d. Date sign		111//		
		1/1/1	111	151		O.C.	M.E.			April 15, 20	012			
	}	30. Name and address of person	who completed cause of dea	r (Item 23a)		-1								
	_]	B - /	ssistant Medical Exa	miner 900	0 W. Bal	timore Stre	et, Baltim	ore, MI	D 21223					
		A Rate ii (2M.2ay, Yes)	32. Registrar	Signature										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last). 2. Date of Death 3. Time of Death Month Physician/ AMES JANTOS 0438 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** or Location of Death 4c. County of Death BALTIMORE >ECOURS SON tos PITAL . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. **Director** 212-88-9830 41 1 XM 2 F Mar.9,1971 Hawaii Usual Residence of Decedent or 28a-f show notified at 10b. County with the Maryland 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD n/a Baltimore ¥ Yes 2 □ No 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe r items 23a o Funeral 7434 Poplar Avenue 21224 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S er than "natural", or iter the Medical Examiner 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Filipino If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 7: ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 Plumbers Apprentice Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paulino Santos Mary Norton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Santos / Brother Baltimore, Continental Drive Suite 128 Newark, DE 19713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or New Cathedral Cem. Apr.18,2012 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 328 Sulphur Spring Road Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each inc. Interval Between Immediate Cause (Final Onset and Death **Physician** disease or condition resulting in death) Medical Due to lar as a consequence of Examine DEMA monder Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (o ESPIRATOR the burial-transit or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dedetached for use as the burial-trands. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ENAL ALLIZE Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes Certificate: To Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After Natural work? 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title & 29c. License number 29d. Date signed (Month, Day, Year) MID. 2012 570720 cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle | ast) 2. Date of Death Physician/ April 2012 Cooper Sperling 10:43 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Mir Director 199-09-2772 95 1 🗆 M 2 🗓 F Jan. 1, 1917 Pennsylvania 28a-f show 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD Montgomery 1 Yes 2 X No Silver Spring 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1131 University Blvd. West #1807 20902 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14 Race - American Indian injury or other traumatic event, the Medical Examiner Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify "natural", White Completed 3 Widowed 4XXDivorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Clerical 12 Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ Morris Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Kenneth Stalberg / Son 127 Brookside Ave., Belmont, MA 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Department of Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State Chesapeake Crematory 04/20/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Ma 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death
HOURS Immediate Cause (Final Physician/ HYPOTENSION disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** SEPSIS HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exam the burial-transit Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year the a g Unknown g | Ilnknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SMALL BOWEL OBSTRUCTION Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏋 Unknown page 2 should neec HYPERTENSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has performed? Yes 2X No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifications. **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ျှ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural Accident 5 Pending work 1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D32332 APRIL 17, 2012 30. Name and address of person leted cause of death (Item 23a) (Type, Print) SURESH K. GUPTA M.D., 9801 GEORGIA AVE. #220, SILVER SPRING, MD 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

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68760 Box (P.0. Records, Hospital or Attending Physician: of Vital Division To the Hospital within 24 hours a To the Funeral C completely filled

State Registrar

DHMH 17 Rev 06-2011

29a. Certifier (Check

29b. Signature and title of certifier

30. Name and address of person who

31. Date filed (Month, Day

JEAN RU JEN HOU,

655 WATKINS MILL RD.,

completed cause of death (Item 23a) (Type, Print)

32. Reginar's Signard

M.D.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D57362

GAITHERSBURG, MD

29d. Date signed (Month, Day, Year)

APRIL 17, 2012

20879

29c. License number

3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death Physician/ even Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Season's Hospice Randallstown Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min onth, Day, Year) 06/11/1955 1 X M 2 □ F Director 214-66-5715 56 Yrs. Maryland Usual Residence of Deceden or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1X Yes 2 ☐ No MD Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Pomona West 21208 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify. Completed 3 Widowed 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales 12 Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Henry Sinar Lois Pass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven L. Bunoski / Brother In Law 407 Red Birch Road, Millersville, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 4/20/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall 1 Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on _____line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, loading to an indicate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Dualto for selevicione actione a con To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi iding physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year g 🔲 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) hernia examiner? Other: Certificate: To 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred VNatural 5 Pending work 1 Yes 2 🗆 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

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Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and b Importsot: If item 27 is usiny or other traumatic		1 Burial 2 X Cremation 3 Removal from State W. Arundel	olace) Crematory 04/1	16/2012	oc. Location - City or Odenton, M	ID
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ψ		30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Balti	more Street, Baltimore,	MD 21223		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #27 Per Phy G926 4/20/2012 Jh State of Maryland Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 17, Day 012 Year 3:50 P M Cinda M. Sengstack Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 1 □ M 2 🗶 F **Director** 577-46-0297 80 June 25, 1931 Utah Usual Residence of Decedent 28a-f show 10a, State 10c. City, Town or Location notified at 10d. Inside City Limits Director Maryland Bethesda Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be Funeral 23a 20817 6931 Greentree Road United States items be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify. "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working than life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Speech Therapist D.C. Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers of is marked or ည Mary Vie Yardley Abe Murdock other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau George F. Sengstack/Husband 6931 Greentree Road, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of April 19, 20c. Location - City or Town, State Page 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Bethesda, Maryland Montgomery Crematorium 21. Signature of Funeral Service License 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home, Bethesda-Chevy
7557 Wisconsin Avenue, Bethesda, Maryland 20814 Chase, Inc. Willer-M01173 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) MP Due to () r as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death been signed by the a should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Myecadia Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Jinda Sengstac 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an completely filled in by the funeral director, page 2 s autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 7. Manper of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director; After Natural Accident 5 Pending injury 1 ☐ Yes 2 No -9// ADY 12 2012 2320 M Investigation 6 Could not be Suicide 28f. Location (Street and Company Ruce Bound Number Rd City or Town, States of the Ruce Bound Number Rd Beld of the Policy ND 20°517 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Dane Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year) 17 2012 edress of person who completed cause of death (Item 23a) (Type, Print) Atul Rohatgi, M.D. 8600 Old Georgetown Road, Bethesda, Registrar

1 - For State Registrar 12455 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Apri Physician/ 2012 Constance 1:15AM STronski Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death UPPER CHEASPEAKE MEDICAL CENTER BEL AIR HARFORD Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min (Month, Day, Year) 218-26-1172 **Director** 1 □ M 2 🕅 F 80 11/28/1931 MARYLAND Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director MD BALTIMORE 1 🗌 Yes 2 💢 No PARKVILLE 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 8106 RIDGELY OAK ROAD 21234 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Completed 3 ♥ Widowed 4 □ Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other t HOMEMAKER 8TH GRADE OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JOHN BAGINSKI BERTHA KULESZA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other troone. ARLENE A. PILLING/DAUGHTER 3300 NORTHWIND RD. PARKVILLE, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOLY ROSARY CEMETERY |4/21/2012 DUNDALK, MD 21/8/117 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Lic see MO1139 8521 LOCH RAVEN BLVD. TOWSON Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Preumonia Ph. sician/ disease or condition resulting in death) Medical 10811S Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Strenski, Constance Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Yes Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) M800605229 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 Inpatient 2 I ER/Outpatient 3 I DOA completely filled in by the funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No To the Hospital or Attending I within 24 hours after death.

To the Funeral Director, After Natural 5 Pending injury Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my oplinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 06-2011

SW

Registrar

29b. Signature and title of certifi

31. Date filed (Month, Day, Year)

2012

Upper Chesapeake Medical Conte

M.D.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shaun Evans Uppe Chesapeak Med

29c. License number

DOD63653

29d. Date signed (Month, Day, Year)

April 18,2012

Bel Air, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) April 12, Day 012 Year 12:48 PMM Physician/ Sally Thurston Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince George's Hyattsville 3405 Toledo Terrace 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) **Funeral** 11/17/1943 213-50-4054 68 California Director 1 □ M 2 💢 F Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State must be notified at Director Hyattsville Prince George's 1 Yes 2 X No Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō U.S.A. 23a 20783 Funeral 3405 Toledo Terrace #E1 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, and 2 should be filed vithin 72 hours after death 27 is marked other than "natural", or iter traumatic event, the Medical Examiner Black White etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed, Prince George's Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) County 4 Librarian Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d Mental I မ Jeanette Jackson Henry Thurston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code

20b. Place of Disposition (Name of

Ardent Cremation

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest,

Physician/ Medical Examiner

Health em 27 other

Department of H Important: If ite any injury or ot

19a. Informant's Name/Relationship (Type, Print)

4 Donation 5 Other (Specify)

Signature of Funeral Service Licensee

1 Burial 2X Cremation 3 Removal from State

shock, or heart failure. List only one cause on each li

Ron Thompson

20a. Method of Disposition

Immediate Cause (Final

29b. Signature and title of

the Hospital or Attending Physician. The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

	disease or condition resulting in death)	Due to (or as a consequ		10/07	01202	
ıminer	Sequentially list conditions, b. cause. Enter Underlying Cause (Disease or injury	Due to jor as a consequ	dence of):			
dical Exa	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):			
Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of a	al death 3 🔲 Ector	oic pregnancy (specify)		23d. Date of delivery Month Day Year
ed by Ph	Part II. Other significant conditions confi		sulting in the universely	ng cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 Unkno
Completed by					24a. Was an autopsy performe 1 \(\sum \) Yes 2	
O	25. Was case referred to medical			26. Place of Death (CI	neck only one)	
To B	examiner?	ospital:	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	e 6 Other (Specify)
	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 Yes 2 No	28d. Describe how	injury occurred
Medical Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	y)		City or Town, S	
Medica	29a. Certifier (Check conly one) 1 ✓ Certifying Physic 2 ☐ Medical Examine 3 ☐ Certifying Narse	cian: To the best of my know er: On the basis of examination Practitioner: To the best	rledge death occurre on and/or investigation my knowledge, death	ed at the time, date and plac , in my opinion, death occurre occurred at the time, date an	e, and due to the cause ed at the time, date and p d place, and due to the d	e(s) and manner as stated. blace, and due to the cause(s) and manner stause(s) and manner as stated.

576 Lightening Ridge Road Plainfield, VT 05667

26382

29d. Date signed (Month, Day, Year)

22. Name and Address of Facility Marzullo Funeral Chapel, P.A.

6009 Harford Road Baltimore, Maryland 21214

20c. Location - City or Town, State

Interval Between Onset and Death

04/19/2012 | Hanover, Maryland

State Registrar

Marc R. Shepard, M.D. 4700 Berwin House Road College Park, Maryland 20740 31. Date filed (Month, Day, Year, 32. Registrar's Signature 2012

we 30. Name and address of Jerson who completed Juse of death (Item 23a) (Typ-, Print)

within 24 hours after death To the Funeral Director:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Day 2012 Physician/ W. Turner 19 Vernon 8:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 1510 Delvale Avenue Dundalk 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Davs Hours 228-12-5951 **Director** 1**X** M 2 □ F 93 Virginia July 24,1918 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Md. Baltimore Dundalk 1 Yes M No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1510 Delvale Ave. 21222 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces "natural", or þ Black White etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any highly or other traumatic event, the Medical Examinance. 1 Never Married 2 Married 1X Yes 2 □ No Baltimore, Maryland 21215-0036 1 Yes X No Specify: Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Millright Construction 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clifford W. Turner Alice McGruder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Turner Wife 1510 Delvale Ave. Dundalk, Md. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 19, 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Licenses ²² Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final disease or condition Onset and Death Physician/ JOSTIC Medical resulting in death) **Examiner** -ABG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury 11507 that initiated events resulting in death) Last Due to (or as a consequence of) Embolism attending physician Physician/Medical Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No fo Pregnant at time of death Month Day detached the ☐ Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ge 2 should be Rocords, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown een 24a. Was an 24b. Were autopsy findings available has autopsy performed Yes 2 prior to completion of cause of death?

1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death s after death. I Director: After t Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi

State Registrar

9

29b. Signature and title of certifier

Mukesta

That WD

1575

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Werritt Blud,

D0024303

29d. Date signed (Month, Day, Year)

21227

04/19

Baltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 9:35 P M 2012 April Terameau Marie Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Mackey Group Home Rockville Montgomery 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Days Min Months 1 □ M 2XX 94 Sept. Haiti Director 578-58-7349 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location 10a. State death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 Yes 2 X No Rockville MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20853 Haiti 5024 Adrian St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Examiner Armed Force Black, White, etc. 0 by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🕅 No Specify If Yes, Give Black. "natural", 3 ▼ Widowed 4 □ Divorced Completed Year or Dates. Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Domestic Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental I 27 is marked o traumatic eve Pierre Salamon 2 Saloman Lesimon Estimon /, Ma.
Je 1 and 2 should be rent of Health and M.
Ant: If item 27 is r 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 415 Silver Spring Ave. #506, Silver Spring, MD 20910 Marc Terameau / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any injury or once. 04/28/2012 Silver Spring, MD Gate of Heaven Cem. ²Rapp and Address of Facility and Cremation Services 20910 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death YEARS Physician/ ALZHEIMER'S DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ Month Year in the past 12 months?
1 Yes 2 X No Day Pregnant at time of death 9 Unknown the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2XXNo 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an autopsy has performed 1 ☐ Yes 2 ☐ No 1 Yes 2 X No certificate 25. Was case referred to medical 26. Place of Death (Check only one) CROTTP Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 $otin{vmatrix} {\bf X} {\bf Other} (Specify) {\bf HOME} \\ {\bf MOME} {\bf OTHER} \\ {\bf OTHER} {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER} \\ {\bf OTHER}$ 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ this 28a. Date of injury (Month, Day, Year)

To the Hospital or Attending Physician: completed filled in by the funeral within 24 hours a

s after death. I Director: After t

Certificate:

Medical

State Registrar

27. Manner of Death

1 X Natural

Accident

29b. Signature and title of ce

Suicide

4 Homicide

29a. Certifier

5 Pending

Investigation

determined

6 Could not be

BARRY N. ROSENBAUM M.D., 3720 FARRAGUT AVE. 2ND FLOOR, KENSINGTON, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

28c. Injury at work?

Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Yes

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D09834

29c. License number

2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

APRIL 16, 2012

20895

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April1 1^{Day} 20 Ĭ[®]Z 3:15 P John Victor Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wilson Healthcare Facility Gaithersburg Montgomery Social Security Number If Under 8. Date of Birth (Month, Day, Ye Oct • 15, 6. Sex 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 ★ M 2 □ F Months Min Year. Yrs Country)
Illinois **Director** 88 317-14-5914 1923 Usual Residence of Decedent 28a-f shov 10a. State 10b. County at 10c. City. Town or Location 10d. Inside City Limits Director notified CO Pueblo W. Pueblo X☐ Yes 2 ☐ No 10e. Street and Number ems 23a or r must be n 10f. Zip Code 10g. Citizen of What Country Funeral 1273 S. Winter Haven Dr. 81007 United States items and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Armed Forces? Black, White, etc. ò 1 X Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. W W II 1 ☐ Yes 2 ☐ No Specify. "natural", 3 ☐ Widowed 4 ☐ Divorced Completed Specify. White event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) 12 College (1-4 or 5+) Engineer IBM Corporation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F ರ Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es once. Sr. Tednor R. Victor Alvina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11810 Enid Dr., Potomac, MD Paul Buckman / Nephew 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 Burial 2XXCremation 3 Removal from State Chesapeake Crematory 04/19/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SIC C disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Year the Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? autops, performed? No Obstruct 1 Yes 2 No 25. Was case referred to medical or Attending Physician: Be 26. Place of Death (Check only one) examiner? Hospital 2 🗆 NG Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) hin 24 hours after death.

the Funeral Director: After thi
mpleted filled in by the funeral 27. Manner of Death 28a, Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 \(\subseteq \text{Yes} 2 🗌 No ☐ Accident ☐ Suicide Investigation
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2.

To the F

complet 3 □ Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar A Robert Busine

29b. Signature and title of certifier

04115

29d. Date signed (Month. Day, Year

116,201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Katherine Venable Apri 17 20°12 8:00 **a**.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3819 Coronado Road Windsor Mill Baltimore Social Security Number If Under 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F Days (Month, Day, Yea, 11–23–1923 Director 230-28-4958 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f sho 10d. Inside City Limits Director Baltimore Windsor Mill 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3819 Coronado Road 21244 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Yes 2 No Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 ☐ Divorced Specify: African-American Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should e filed within 72 | h and Mental Hygiene. 7 is man ed other than "r Elementary/Seconday (0-12) College (1-4 or 5+) LondonFog Seamstress 8th event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Junius Street Burley Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vanessa Bass/ Daughter 3824 Coronado Road, Windsor Mill, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 4-21-2012 Woodlawn, MD 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition 2heimeri Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 No signed by the a ld be detached f 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy this certificate 2 🗌 No Yes 2 🛣 No 1 Yes Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: ျ 1 Yes 2 No 1 Inpatient 2 Impatient 2 Impatient 3 Impatient 2 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impatient 3 Impa 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated RU84758 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1838 Greene Tree Rd Pikesville md CKN (State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day -19-2012 Physician/ Month 2:30A M Leonora Viola Wingo Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours 219-18-3610 **Director** 1 □ M 2 F 88 01/26/1924 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Salisbury MD Wicomico ō 10e. Street and Number 10f. Zip Code UNI ms 23a or must be r 10g. Citizen of What Country? Funeral Pine Bluff 21801 items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ ò 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify: White "natural" 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker of Health and Mental Hygie If item 27 is marked other or other traumatic event, the 12 own home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ UNK Page 1 and 2 should be William Lemouth Whitmer 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a 11 Alton Pl Kathleen Gene Pokrywka Berlin MD 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ō Department of Important: If any injury or once. Ardent Crem 4/20/2012 Hanover MD Signature of Funeral Service License 22. Name and Address of FacilityPhillip A Weatherford FS P A 2431 E. Oliver St baltimore Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ tulmonary Chronic Obstructive disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** cadent ere provasular Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Seizure Disorder and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed 2 No Yes 2 No 1 Yes Physician: funeral director, Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) 1 Yes 2 No Other: ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Natural injury work?
1 Yes 2 No 5 Pending Accident
Suicide, Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) D563/2 APR 19 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 🗸 - Stammas MD FHM 733 teal Huvan orn W 31. Date filed (Month, Day State 21811 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

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san Winslow		State of Maryland / Departme 1- For State Certifica	nt of Health and Mental l te of Death	Hyglene Reg. No. 20	12 1246							
Physici dical Exam		1. Decedent's Name (First, Middle,Last) Susan Kent Winslow		2. Date of Death Month Day Year	3. Time of Death 1916 hrs							
)		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	April 3, 2012 ath 4c. County of De								
		Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Baltimore									
Funeral Director		007-58-3594 _{1□M 2} √F 56	**		Birthplace (State or reign Country)							
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	r Location		10d. Inside City Limits							
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with the Maryland ns 23a or 28a-f sho be notified at once	Director	3700 Stansbury Mill Road	10f. Zip Code 21131	10g. Citizen of What C	ountry?							
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Tatending Physician: The law requires that the death certificate be executed referred. The law requires that the death certificate be executed rector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burnal - transitions.	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown 2 Unknown 2 Unknown 3 Unknown 3 Unknown 3 Unknown 4 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5 Unknown 5	Fetal death 3 Ectopic pregr Other (Specify)	nancy 23d. Date of deliv	ery Day Year							
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To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in b	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death one) Wedical Examiner: On the basis of examination and/or involved.										
7 wi. 7	§	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (M	fonth, Day, Year)							
and		D-VL.	O.C.M.E.	April 5, 2012								
K.		30. Name and address of person who completed cause of death (Item 23a)	900 W. Baltimore Street Balti	moro MD 24222	· · · · · · · · · · · · · · · · · · ·							
C+	ate	Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Moath_Day, Year)		more, MD 21223								
Regist	rar	31. Date filed (Month, Day, Year) 2012 3. Registrar's Signature	arked									

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month 2012 Physician/ 7:15 19, April Charles Edward Warfield Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Parkville 9410 Fullerdale Avenue 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 Year Days 5. Social Security Number **Funeral** Hours 1 **X**M 2 □ F 85 **Director** 219-20-8242 Maryland Oct. 18, 1926 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No Parkville Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Numbe Examiner must be United States of America 23a Funeral 21234 9410 Fullerdale Avenue items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1XX Yes 2 ☐ No If Yes, Give Ь þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) C&P Telephone Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental F 27 is marked of traumatic ever မ Margaret Ellen Debelius Owen Dorsey Warfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9410 Fullerdale Avenue, Parkville, MD 21234 f Health aitem 27 i Doris M. Warfield - Spouse 20c. Location - City or Town, State item 20b. Place of Disposition (Name of 20a. Method of Disposition metery, crematory or other place) April 23, 2012 1XXBurial 2 🗌 Cremation 3 🗌 Removal from State Important: It any injury or once. Baltimore, Maryland 4 Donation 5 Other (Specify) Cemetery Parkwood Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lediate Cause (Final Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road, Parkville, Maryland 21234 Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to sa onsequence of **Examiner** Sequentially list conditions Examiner if any, leading to immediate that initiated events Due to (or as a consequence of): resulting in death) Last physician ar s the burial-1 Be Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consequent at time of death 5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Month Dav in the past 12 months? Yes 2 No 9 Unknown P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 2 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy the funeral director, page 2 performed 2 🗆 No 1 Tes Yes 2 X 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA ည 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: work? 1 ☐ Yes 2 ☐ No Natural Accident 5 Pending Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide filled in by determined within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier only (ne) 29c. License number 29b. Signature an ause of death (Item 23a) (Type, Print) 30. Name and address of person who completed o

Registrar

DHMH 17 Rev 06-2011

State

			Pleas	e Type or State o			ndelible I artment of			_		Legible			
			State Registrar				tificate of				Reg. No.	201	2 1246		
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	Funeral Director			Sex 1 X M 2 □ F	7. Age (In yrs. la		If Under 1 Year Months Day		er 24 Hrs. Min.	8. Date of Bii (Month, Da	th	9. Bi	rthplace (State or Foreign ountry)		
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	ith the l	ral Di	10e. Street and Number 8801 Stoneridge	Cirolo A	'		10f. Zip Code 21208	9				zen of What C	*		
	leath w items ? er mus	Fune	11. Marital Status		dent Ever in U.S		Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)					4. Race - Am	erican Indian,		
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	1 X Yes 2 □ No If Yes, Give 1 Year or Dates.			☐ Yes 2X	No Specify		rican, etc.)		Black, Whi Specify: Wh:	ite		
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	2	1 Yes 2 2 27. Manner of Deat	XNo	Hospital:		-	ER/Outpatien 28b. Time of		Other	4 X		me 5 Res					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Thelm 7:30A M Demetra 13 Apri Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 906 S. Pine Ridge Court Bel Air Harford If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months **Director** 1 🗆 M 2 🖳 F 213-76-7681 55 10-5-1956 Ohio Usual Residence of Deceder works i 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Md. 28a-f Harford Bel Air 1 Yes X No 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? 23a (Funeral 906 S. Pine Ridge Court 21014 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examinonce. ģ 1 Never Married 2 Married ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☐ No Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Pre-School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ **ELEFTHERIOS PANTELOUKAS** DESPINA PSALTAKIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 906 S. Pine Ridge Court Bel Air, Md. 21014 George Wilhelm 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1x Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Demetrios 4-17-2012 Cub Hill, Md. Signature of Funeral Service Licer see 22. Name and Address of Facility Schimunek Funeral Home, Inc. B. O. 610 W. MacPhail Road BelAir, Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Lymphoma Burkits disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as 1 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Month Year Dav Pregnant at time of death 5 Other (specify) n signed by the a 1 Yes 2 L Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate has 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 06-2011

10

29b. Signature and title of certifier

NS Kajapakse MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C835 Smith DV

32.

29c. License number

DOOS 7465

29d. Date signed (Month, Day, Year) 4/13/12

21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year April 4:00 PM Medical 2012 4a. Facility Name (if not institution, give street and number **Examiner** 4c. County of Death Memoria **Funeral** 7. Age (In s. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Director 1 □ M 2 🗷 F show 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b County . City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No TIMORE 10g. Citizen of What Country? Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc 1 ☐ Yes 2 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify Completed 3 Divorced Year or Dates. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) Be permit, Page 1 and 2 st Department of Health ar Important: If item 27 is: 19b. Mailing Address Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 1 Burial Cremation 3 Removal from State 20/2012 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. ng, such as cardiac or respiratory arrest Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Dehydration severe week Medical Due to (or as a consequence of) Examiner Bowe Sequentially list conditions, Obstruc week Examine cause (Disease or injury that initiated events Due to for as a consequence of,: Stage the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Metastatic months Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery signed by the atter 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year 2 No g Unknown g Unknown P.O. g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?/ Yes 2 No certificate I Division of Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury s after death filled in by the Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific AT2438946 April MO 2012

State

Registrar
DHMH 17 Rev 06-2011

11. Date filed (Month, Day,

APR 2 0 2012

Baltimore

ai. Union Memorial Hospital, 201 E. University Parkway

32. Regittrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3:48PM 04 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death VIEW DALTIMORE KOLAND . Age (In yrs. last birthday) If Under 24 Hrs. If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min. 1 XM 2 □ F Director 1-19-MD show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BAUTIMORE Yes 2 ☐ No MD 10e. Street and Number 10g. Citizen of What Country? Funeral OLAND 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates 1 ☐ Yes 2 WNo Specify: Completed 3 Widowed 4 Divorced BLACK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired)

E- KELENSE OFFICEK (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ORRECTIONS Be 17. Father's Name (First, Middle, Last) NONIE Department of Health and Ment Important: If Item 27 is marke any injury or other traumatic ILLIAM AWSON Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2809 ISLAND.14 61201 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State BALTIMOLE, MD 4 ☐ Donation 5 ☐ Other (Specify) GREENE FUNERALSONS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pulmary CHRONIC Obstructive disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No ☐ Pregnant at time of death☐ Unknown the 9 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform 2 No 1 Yes Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home မ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes hours after death. 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Gertifying Nurse Practitioner: To the best of my knowled detti- tre 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M0 12 D0059056 and address of person who completed cause of death (Item 23a) (Type, Print) MUH 40th 102 St Baltimore MD 102 31. Date filed (Month 32. Registrar's Signature State APR 2 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ LOUISE WISEMAN APRIL 17, 9:42 P M 2012 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DOVE HOUSE WESTMINSTER CARROLL 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Hours 218-26-3173 **Director** 1 □ M 2**X** F 80 Yrs. 4-30-1931 NEW YORK Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location with the Maryland must be notified at 10d. Inside City Limits Director BALTIMORE MD PERRY HALL 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 9600 H HAVEN FARM ROAD 21128 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 9 þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: ₩ Widowed 4 Divorced WHITE "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname and Mental WEST ပ MOSES ODO YOUNG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 948 RIDGE RD APT FRANK A. WISEMAN, III./SON 1 WESTMINSTER, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 🙀 Burial 2 🗆 Cremation 3 🗆 Removal from State ō Department of Important: If any injury or once. GARDENS OF FAITH 4-21-12 BALTIMORE, MD Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death FAILURE Physician/ HEART disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner FIRPICLATION quertially list conditio if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnag 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 mont Month Day Year Pregnant at time of death g Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underline g cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? After this certificate I 2 No 1 🗌 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) (NFATT + 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No 1 Natural injury 5 Pending Investigation after death filled in by the Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

State Registrar

Medical

29a. Certifier (Check

only one) 29b. Signature

Certifying Nurse

d title of certifie

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First Middle | ast) 2. Date of Death Physician/ Dav Rameshchardra Ambalal Zaveri April 2012 9:33 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery <u> Holy Cross Hospital</u> If Under 7. Age (In vrs. last birthday) Year If Under 24 Hrs. Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 152-52-9407 1 🛛 M 2 🗆 F 63 1948 Usual Residence of Decedent June 17, India 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2X No Maryland | Silver Spring Montgomery ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 11210 Legato Way 20901 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" 3 Divorced 4 Divorced Year or Dates Asian Indian event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Soil Technician ECS Mid-Atlantic, LLC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Nirmala Ambubhai Parikh traumatic Ambalal Anandalal Zaveri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a 11210 Legato Way Silver Spring, Maryland 20901 Lilaben R. Zaveri / Wife injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If it any injury or of cemetery, crematory or other place) 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Arundel Crematory: 4-14-2012 Odenton, Maryland Signature pir uneral Service Liceosee

22. Name and Address of Facility
Donaldson Funeral Home & Ci
1411 Annapolis Road Odentor

a. Rapt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland Approximate Interval Between Onset and Death

1 day Immediate Cause (Final Physician/ Acute Hypoxia disease or condition Medical resulting in death) **Examiner** Metastatic Kidney Cancer 1 year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami the burial-transi Kidney Cancer 3 years that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? signed by the atter Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Hypertension 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 X No Hospital or Attending Physician: 24 hours after death. Division of Vital Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🛚 No Other: 2 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After t 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number

State Regist<u>rar</u> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Linda Burrell, MD.

31. Date filed (Month, Day, Year)

APR 2 0 2012

D35996

2730 University Blvd. #400 Wheaton, Maryland 20902

April 11, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Douglas Anderson, Sr. April 20**1**2 6:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Baltimore Randallstown Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year)
Dec. 10,1919 577-14-7395 Days Hours Director 1 🛛 M 2 🗆 F 92 VA 28a-f show 10a. State with the Maryland 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director Sykesville 1 Yes 2XXNo Maryland Carroll 5 10e. Street and Number 10g. Citizen of What Country must be 23a Funeral 5600 Strawbridge Terrace 21784 United States death v items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, the Medical Examiner Armed Forces? 1945 Black, White, etc 9 þ 1 Never Married 2 K Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify. "natural", 1947 Specify. White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Greenspring Dairy Mechanic 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Department of Health and Ment, Important: If item 27 is manany injury or any Richard Anderson Mabel Flester Hutchins pe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Dorothy Anderson Wife 5600 Strawbridge Terrace Sykesville, MD 21784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
South Carroll Crematory 4/25/12 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Sykesville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, PA 1212 W. Old Liberty Road Sykesville, MD 21784 sa Part / Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Exam Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be exee
24 hours after death.
 Funeral Director, After this certificate has been signed by the attending physician a
selly filled in by the funeral director, page 2 should be detached for use as the burialselly filled in by the funeral director, page 2 should be detached for use as the burialindicate. Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? 2 🗌 No 1 Yes 1 Yes 25. Was case referred to medical examiner?

1 \(\sum \) Yes 2 \(\sum \) No Be March 26. Place of Death (Check only one) Other: ဂ္ 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aff

To the Funeral Di

completely filled in Medical 29a. Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the

State Registrar (Check

only one) 29b. Signature and title

30. Name and address of person who completed

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dedro Month Perez Alonso 1945 M 18 Ö4 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center **Baltimore City** Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year) Jan 16, 1938 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 584-03-8820 Cuba Director 1<u>M</u>2 D F Usual Residence of Decedent 28a-f shov 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director MD Howard Columbia 1 🗆 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8411 Glad Rivers Row 21045 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces Black. White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married 1 X Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Owner Bakery and Mental Hygien is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Pedro Perez Caridad Perez traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Lydia Poole 8411 Glad Rivers Row Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory, LLC Apr 23, 2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ nulmonory embolism disease or condition resulting in death) Medical Examiner thalamic stroko Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No

9 Unknown Month Year Day Pregnant at time of death the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 performed? Yes 2 N After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ္ SInpatient 2 □ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. Natural 5 Pendina 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier AU4176435W101570 MD30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street, Boutimore MD 21201 BETLAMY Weller MD

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 8:00A M ar rowr Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Min **Director** 1 □ M 2 🗹 3-28-1925 28a-f show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Neyer Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru al Route Number, own, State, Zip Code) 201 avid 20a. Method of Disposition 20b. Place of Disposition (Name of 1 W Burial 2 Cremation 3 Removal from State emetery, crematory 4 Donation 5 Other (Specify) 4-30-2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaval n Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician Lementi A disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 1 Yes 2 9 Unknown the be detached Division of Vital Records, P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by evtension 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' this certificate Yes 2 No 1 Tes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completely filled in by the funer Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioners To the best of my knowledge ensated the to-29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 105 9.2012 \mathcal{N} \mathcal{N} \mathcal{N} ADVI 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) "CHAVLES Street Baltmore 5901 North Don m-D Ano 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month APR I 7012 1:48P tarry Brown Medical 4a. Facility Name (if not institution, give street and number) Examiner eason Canda STOWN If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Hours 4030 Director 1 M 2 D F show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important if flem 27 is anarked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Completed by Funeral Director 1 Yes 2 No 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 501 Be Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cometery, crematory of other, 20c. Location 20a. Method of Disposition ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) er VICE Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ cancer LUNG disease or condition Medical resulting in death) Due to for as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23h Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Pregnant at time of death 2 No a 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 6 Other (Specify) hospice Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred injury Natural 5 Pending 2 No 2 Accident Investigation 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MSky apathe MO 00057465 4/19/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltman MD 21209.

DHMH 17 Rev 06-2011

State Registrar NS Rajapaksemo

Date filed (Month, Day, Year)

2835 Smith N 5703

rar's Signature

Patient Known as Henry Lee Brown Baltimore. Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AMonth 1726PM Henry Lee Brown 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospital do Baltimore Baltimore 6. Sex If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 218-58-5263
Usual Residence of Decede **Director** 1**▼** M 2 □ F 58 Dec 10, 1953 South Carolina show 10a. State with the Maryland must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD Baltimore 1 ¥ Yes 2 □ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21215 4005 Wabash Avenue USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Deceue... _ Armed Forces? ¹ ☐ Yes 2 🗓 No 14. Race - American Indian, the Medical Examiner Black, White, etc. 0 1 Never Married 2 Married ģ 1 ☐ Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural", Specify: black Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) maintenance man apt complexes permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lula Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adelsia Brown/aunt 3939 Roland Avenue #407 Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🗓 Other (Specify) in state Euneral Service Rona I d S Wade State Anatomy Board 655 W. Baltimore Street Baltimore. MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death -Physician/ ntecranial disease or condition deis Medical resulting in death) Due to (or as a consequence of Examiner pertension Un)Choron Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death Unknown signed by the at Id be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown plnous Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? certificate 1 🗌 Yes 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) မ 1 npatient 2 🗆 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 🗌 Yes 2 🗌 No filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier alen 10,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anisha Bassa, MD Sinau 17 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 20ÏŽ Harriet Geraldene Berge Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** . Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours 392-22-1093 Director 86 1 M 2 X F July 30, 1925 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director MDCarroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be 1 iral", or items 23a Examiner must b Funeral 7200 Third Avenue Apt. M508 21784 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 X Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the Jany injury or other traumatic event, the Land Cafeteria Work Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Thomas Alfsted Gladvs Alfsted 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Thomas W. Berge (Spouse) 7200 Third Avenue M508, Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 X Removal from State West Valders Cemetery 4/28/2012 4 ☐ Donation 5 ☐ Other (Specify) Valders, WI 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO box 195 Sykesville, MD 21784 M00764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ ongestive disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day signed by the at 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate Yes 2 -1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 52035 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster CHACKO Date filed (Month, Day, Year)

3. Time of Death

2:55AM

WI

1 Yes 2 X No

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DHMH 17 Rev 06-2011

State

Registrar

APR 2 3 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2017 210 FRANCES BURNETT Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AMNE WASHINGTON MEXICAL 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Director 215-28-4883 1 M 2 XX 80 JULY 21 1931 MARYLAND Usual Residence of Decedent artment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No ABERDEEN HARFORD CO MARYLAND 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 438 HOLLEY DRIVE 21001 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: Specify: BLACK 3 XiXwidowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) FEDERAL GOVERNMENT COMMUNICATION 12vrs <u>2yrs</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARY CURRY ALBERT ALLEN 3ugner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Cherry Hill Rd. Apt 350, Baltimore, Md. 21225 Sing Allen/Brother Method of Disposition 20b. Place of Disposition (Name of Date unk 20c. Location - City or Town, State cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State Other (Specify) 4 Donation 5 ARLINGTON NATIONAL ARLINGTON, VIRGINIA 22. Name and Address of Facility
WILLIAM C BROWN
1206 W NORTH AV VN COMM FUNERAL HOME P.A. AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami and -tran that initiated events Due to (or as a consequence of) resulting in death) Last burial the attending physician thed for use as the burian Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mg 5 Other (specify) Pregnant at time of death been signed by the a should be detached Linknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an eral Director: After this certificate has filled in by the funeral director, page 2 performed?

Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred after death. Director: After (Month, Day, Year) Natural 5 Pending М 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who compl leted cause of death (Item 23a) (Type, Print) dive Glen Burne MD 301 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2/1 ate of Death 3. Time of Death ent's Name (First, Middle, La **Physician** /Medical not institution, gi 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year)
Mar 12, 1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 TF Illinois 203-30-2667 85 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State show 10b. County Examiner must be notified at 1√ Yes 2 □ No Director MD Baltimore 28a-f 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō 21213 USA 3321 Lyndale Avenue 23a Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, be filed within 72 hours after de Ital Hygiene... d other than "natural", or item Black, White, etc. 1 Yes 22 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Specify. ģ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education unk unk (Give kind of work done dife. DO NOT use retired) during most of working (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be and 2 should be tealth and Mental I is marked Stephen Osbourne ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health i 3321 Lyndale Avenue Baltimore, MD 21213 Lillian Smith/friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1Department of He
Important: If iten
any Injury or oth 20a Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Scensee Ronald S. Wade, 23 Name and Address of Facility Board 655 W. Baltimore Street Dixector 21201 Baltimore, MD Enter the disease, or complications k, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Orset and Deatl Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): nding physiciar Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ed by the att 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 2 No 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 2 No 2 ER/Outpatient 3 DDA Inpatient 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 2 Accident or Attending 2 □ No death. 1 Tes 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only one) 29b. Signature and title of certifier 29c. License number Day, Year,

State Registrar and address of p

Saltimore, Maryland 21215-0036

Box 68760

P.O.

of Vital Records,

Division

4940 Eastern Avenue, Baltimore, MD, 21224

mpleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		٠	For State Registrar	State of I	viaryiar		artment of I tificate of I		and iv	ientai Hy			0 1010	
		1. Decedent's Name (First, Middle, Last) 2. Date of Death						201	3. Time of Death	t				
		Physician/ Medical ROSEMARIE BONCZEW			NCZEWS	KI	I Month APRIL			. 18	Day 18, 2012 8:21 P M			
and the	Examir	er	4a. Facility Name (if not institution	f not institution, give street and number) 4b. City			4b. City, Town, o	r Location o	of Death		40	c. County of Dea	ath	
1			GILCHRIST HOS 5. Social Security Number					rowson			\perp	BALTI		_
	Funeral Director		213 - 72 - 0795	6. Sex 7 1 □ M 2 X F	Age (In yrs. I	last birthday)	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da			lirthplace (State or Foreign country)	
			Usual Residence of Decedent	I L MI ZALI	55	Yrs.				08/03/	1956	5	DC	
	/land f sho	tor	10a. State 10b. County		10c. Cit	ty, Town or Loc	cation						10d. Inside City Limits	
	Mary 28a- otifie	Director	MD N/	A		BALT	IMORE						1 X Yes 2 ☐ No	
	th with the Maryland ms 23a or 28a-f show must be notified at	al	10e. Street and Number				10f. Zip Code				10g. Ci	itizen of What C	Country?	
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တ		by Fi	1X Never Married 2 ☐ Ma	Armed Forces	27	5. 15. V	Vas Decedent of H Yes, specify Cuba	an, Mexican	n, Puerto F	Rican, etc.)		14. Race - Am Black, Whi		
03	2 hours aft "natural", dical Exal	ed k	3 🗆 Widowed 4 🗆 Divorced	If Voc Civo		1	☐ Yes 2 🛣 No	Specify:				Specify:	WHITE	
21215-0036	72 hours after n "natural", or ledical Exami	Completed		nt's Education est grade completed)			ent's Usual Occup		t of workin	na	16b. K	Kind of Busines	s/Industry	
121	within 72 giene. er than , the Me	E O	Elementary/Secondary (0-12)	College (1-4 c	or 5+)	life. DO	O NOT use retired)			_				
	ed wit Hygie other	Be	17. Father's Name (First, Middle, Last)		CLI		NICAL SOC						<u>VORK</u>	
Maryland	I and 2 should be filed within 72 hour Flealth and Mental Hygiene. Item 27 is marked other than "natu other traumatic event, the Medical	욘	RAYMOND	· ·	ICZEWS	КТ		ROS		(First, Middle, MARY	iviaiden	,	ROCKI	
ary.	nd M nd M s mar		19a. Informant's Name/Relations		CZLWD	1	g Address (Street				er City o			٦
	d 2 shalth a alth a 27 is		GAIL KNOPF/ DON	riend ESTIC PARTN	EP.		RED CEDAI							
ore,	of He fitem	1	20a. Method of Disposition		20b. F	Place of Dispos	sition (Name of patory or other place			ate		ocation - City o		_
<u>Ĕ</u>	Page ment ant: I		1 🕅 Burial 2 □ Cremation 4 □ Donation 5 □ Other (3 □ Removal from Sta Specify)		-	RIENDSHII		04/20	/2012		BALTIMO	ORE, MD	
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other		21. Signature of Funeral Service	Licenses	•	22.	Name and Addres	ss of Facility	y SOL	LEVIN	SON	& BROS.	, INC.	
			23a. Part 1. Enter the disease, o	complications that caus	ed the deat							, , i de la j	Approximate	
	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition disease or condition a. Hetastatic Causer of Unknown Remary a.							Interval Between Onset and Death				
	Medical Examiner		resulting in death)	Due to (or a	s a consequ	uence of):	J	0000	100				-	_
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		ğ	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 🗗 (or a	is a consequ	e of):								
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3760	ficate g phy as the										-			
x 68	eath certific attending I for use as	Physician/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregna	incy	Ectopic pregnanc	°V			Į.	23d. Date of de	elivery	
Box	death he att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnan 9 ☐ Unknow	t at time of c	death 5	Other (specify)	· ·				Month	Day Year	
P.O.	at the d by t letach		Part II. Other significant conditions contributing to death but not resulting in the underlyi					en in Part I		noo Did t	tobacco use contribute to the cause of death?			_
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Division of Vital Records,	aw re	ople								24a. Was		24b. Were at	utopsy findings available completion of cause of	
Re	The l	Sol									rmed3	death?		
ta	ician: certifi rector	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 K No	Hospital:			26. Pla	ace of Deat	h (Check	only one)				
) \	Phys	잍	1 ☐ Yes 2 🗷 No 27. Manner of Death	1 Inpa		ER/Outpatient 28b. Time of	28c. Injury	4 L. Nu	-			Other (Spe	cify) Hospue	_
n c	nding tth. : After e fune	Certificate:	1 Natural 5 ☐ Pendir 2 ☐ Accident Investi	ng (Month, E	Day, Year)	injury	work	Yes 2	- 1	8d. Describe h	iow injur	y occurred	·	
isio	Atter	ij. ij.	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of I			et, factory, office			8f. Location (S	Street and	d Number or Ru	ural Route Number,	
Ρį	tal or rs after al Dir	္တ္က [building, e	etc. (Specify	")			-	City or Tou	n, State,)		1
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 ☐ Medical E	Physician: To the best of the basis of Nurse Practitioner: To	examination	and/or investi	gation, in my opinio	n, death occ	curred at t	he time, date a	and place	and due to the	cause(s) and manner states	d.
_	Voith Com		29b. Signature and title of certifie	100			29c. License	number			29d. Dai	ite signed (Mont	th, Day, Year)	\exists
			I WAR	hhas A			D72	134			Ap.	rx 19"	2012	
7			30. Name and address of person SYED Q ABBA	SMD 670	IN Ch	reles St	Seule 4	105 1	Balli	invore	MD	21204	1.	
	Stat Registra	-	31. Date filed (Month, Day, Year) APR 2 3 201	32. Regis	trar's Signat	de la	1							
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DHMH 17 Rev 06-2011

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Carmen Jeffry C) ec	1- For State Certificate of I		, ,	201	2 121.8			
Physici	an/	Decedent's Name (First, Middle, Last)		2. Date of Deat	g. No.	3. Time of Death			
Medical Exami	inei	CARMON Jeffrey C	REdito	Month April 20, 20	Day Year 012	1645 hrs			
		4a. Facility Name (if not institution, give street and number) 4b.	City, Town, or Location of Dea		4c. County of Deat	h			
			Havre de Grace	- lo D	Harford				
Funeral Director			If Under 1 Year If Under 24H Months Days Hours M		(MM/DD/YYYY) 9. Bi	gn 🕜			
		2/4-64-0836 1⊠M 2□F 56 Yrs. Usual Residence of Decedent		SEPT 1	9, 1955	ountry) PA -			
any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
and f show	þ	MARYLAND HARFORD HAVE &	e GRACE Of. Zip Code			1 Yes 2 No			
ith the Marylar 23a or 28a-f i notified at on	rect	10e. Street and Number		10	g. Citizen of What Cou	•			
ith the 23a o	a D	10e. Stfeet and Number 40 Robinhood Rd Lof # 705	21678		U.S.				
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral Director	1 Never Married 2 Married Armed Forces? If Yes,	ecedent of Hispanic Origin? (: specify Cuban, Mexican, Puen		14. Race - Amer White, etc.	ican Indian, Black,			
iffer d		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes	es 2 X No specify:		Specify:	White			
ours a	d by	during most	Usual Occupation (Give kind or of working life, DO NOT use re		16b. Kind of Business/	Industry			
0036 within 72 h gene. eer than "r Medical R	plet	Elementary/Secondary (0-12) College (1-4 or 5+)	Hechan!	- 1	Courania	Hechmical			
5-00; led with: tygiene, other ti	Completed			ne (First, Middle, M		- Comment			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	CARNEN GEORGE CREd,	to MA	2,10	Knies	her			
D 2121 should be f and Mental 7 is marked natic event,	흔	19a. Informant's Name/Relationship (Type, Print)	dress (Street and Number or	Rural Route Numb	er, City or Town, State	, Zip Code) 2/224			
e, MC t and 2 si Health ar item 27		Michelle Kynn Credito- 28	5. HIGH/A	vd /tuc	NUE BA	to Ha			
F = 6 S ⊆		1 Burial 2 Cremation 3 Removal from State crematory or other	nlace)		20c. Location - City or				
그는 전 월 등 다		4 Donatign 5 Other Specify: West Asus	udel CARM. 4	24-2012	Oderter	MARYMOD			
Balt permit. Depart Impor		21. Signal for of Fune of Service Licensee 22. Nam	e and Address of Facility	oscpl 1	1 ZANNII	OF TRE.H.			
Physician	-	234. Part I. Enter the disease, or complications that caused the death. Do not enter the r	node of dying, such as cardia	or respiratory arres	t, shock, or heart	Approximate Interval			
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Methadone Intoxication				Between Onset and Death			
zxammer		or condition resulting in death) Due to (or as a consequence of):	. -						
	9	Sequentially list conditions, if any, leading to immediate							
	Examiner	cause. Enter Underlying Cause (Discass or Injury that Initiated c.							
xecuted xecuted - transit	Exa	events resulting in death) Last Due to (or as a consequence of):							
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760, cate be	₩ E	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery				
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30x death e atter	ysic	1 Yes 2 No 9 Unknown 9 Unknown	(Specify)		ŀ	/4			
P.O. Box 68760, res that the death certificate be existened by the attending physician be detached for use as the burial.		Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?			
S, P.	od by			1 Yes	2 No 3 Prob	ably 4 🗸 Unknown			
cords, law requirements been so 2 should	Completed			24a. Was an autopsy		opsy findings available empletion of cause of			
Recc The lav cate ha	E			perform 1 ✓ Yes 2	ed? death?	2 No			
tal Rec	8	25. Was case referred to medical examiner?	26. Place of Death (Check	only one)					
Physical direction	의	1 Yes 2 No rospital 1 Inpatient 2 ER/Outpatient 3			esidence 6 🗸 Other:	Scene			
on of ading Plat. T: After ie funera	흲	1 Natural 5 Roading (Month, Day, Year)	1 Von 2 1 10	28d. Describe how	v injury occurred				
risic r Atte ter dea irectoi	<u>licat</u>	2 Accident Investigation 28e Place of Injury - 4t home form street fa	181		eet and Number or Run	al Route Number City			
Divisior Hospital or Attend 24 hours after death Funeral Director:	Certification:	Suicide 6 Could not be determined (Specify) Fd:Residence		or Town, Stat	e)14 Chestnu Grace,MD.	it St.			
e Hosp 124 ho e Fune etely f		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a		due to the cause(s	s) and manner as state				
Division of Vital Records, P.O. Box 68760, within 24 hours after death. The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.							
	2	29b. Signature and title of certifier	29c. License number		9d. Date signed (Moni	h, Day, Year)			
M M		O.C.M.E. April 21, 2012							
ON COLO		 Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore S 	treet, Baltimore. MD 21	223					
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature							
Renistr	ar	APR 9 3 2012 A				1			

Division or Vital Records, P.O. Box 68760,

State Registrar

(Check only

29b. Signature and title of contine

31. Date filed (Month, Day,

N

Year,

and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3:05 AM April 21 2012 Dorothy Joyce Clemente Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Stella Maris Hospice Lutherville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year)
Jul 13, Days Min 76 United Kingdon **Director** 578-52-2591 1935 1 🗆 M 2 🔀 F Usual Residence of Decedent 28a-f show 10a, State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 1 Yes 2 No Rosedale Baltimore 0 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be I "natural", or items 23a Funeral 9577 Shirewood Ct. 21237 United States Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Hospitality Industry 12 Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည Elsie Ellen Reeves Ernest Edgar Meadows 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Pamela Leahy /Daughter 9577 Shirewood Ct. Rosedale, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Apr 23 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Signature of Funeral Service 22. Name and Address of Facility Cremation and Funeral Alternatives Ke Dicca 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final STENDS AORTIC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 2 🗌 No Yes 25. Was case referred to medical or Attending Physician: director, Division of Vital Be 26. Place of Death (Check only one) Other: 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Cother (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Accident 5 Pending 2 🗌 No Investigation within 24 hours after deal To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier R043580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Rd-Timonium M21093 vlovey Valke

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep					
				rtificate of Death	Reg. No. 2012 12484			
	Physicia		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month April 4, 2012 3. Time of Death 6:15 PM M			
3 Jq	Medic Examin		Marilee C. Considine 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death				
	LAGITIM	CI	1409 Walnut Avenue	Baltimore	Baltimore			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country)			
7	Director		284-18-3903		Nov 3, 1923 Maryland			
	and show I at	or	10a. State 10b. County 10c. City, Town or Lo	peation	10d. Inside City Limits			
	Maryl 28a-f otifie	irec	MD Baltimore Bal	timore	1 ☐ Yes 2X☐ No			
	th the	Funeral Director	10e. Street and Number	10f. Zip Code 21209	10g. Citizen of What Country? USA			
	ath will	uner	1409 Walnut Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13.					
0	er dec or ite miner	by Fi	1 U Never Married 2 U Married 1 Yes 2 K No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Black, White, etc.			
200	urs aft ural", al Exa	ted	3 🔀 Widowed 4 □ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 X No Specify:	Specify: white			
ις Γ	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ding 16b. Kind of Business/Industry			
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מ	filed val Hyg	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Surname)			
Z	Ment Ment narke	ပ္	Charles Arthur Carlson	Grace	Cogger			
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at			ng Address (Street and Number or Run 9 Walnut Avenue B.	al Route Number, City or Town, State, Zip Code) altimore, MD 21209			
ore,	ige 1 and nt of He tri lf item		Build 2 Gremation of Tremoval normatate	osition (Name of matory or other place)	Date 20c. Location - City or Town, State			
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or of		4 Donation 5 Othe (Specify) 21. Sig at e o Roma College Diffector 2	Name and Address of Facility State Anatomy Boar	d 655 W. Baltimore Street			
_		_	Com I	Baltimore, MD 212	.01			
Physician Medic	Discourie i e e e e		23a. Part \ Enter the disease, or complications that caused the death. Do not ent shock, culeart failure. List only one cause on each line.		Interval Between			
	Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	LUNG CA	neek 3 months			
	Examiner	,						
	- ·	iner	Sequentially list conditions, if any leading to immediate page 1. Due to jor as a consequence of cause. Enter Underlying					
	be executed sician and burial-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
0	be ex sician buria	dical	d d					
09/89	ficate g phy as the	Medi						
ŏ ×	h certi tendin or use	lan/	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐	☐ Ectopic pregnancy	23d. Date of delivery			
O. BOX	the deat by the at ached fo	Physician/Me	1	Other (specify)	Month Day Year			
יר	s that gned b		Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobacco use contribute to the cause of death?			
ds,	equires sen siç nould l	ted	Chronic Obstructive fulma	DNAIY DISCA.	1 Ses 2 No 3 Probably 4 Unknown			
Records,	has b	Completed by		·	24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?			
ř	n: The ficate or, pag		25. Was case referred to medical	00.01	1 Yes 2 No 1 Yes 2 No			
VItal	s certi	To Be	examiner? 1	26. Place of Death (Check	ome 5 Residence 6 Other (Specify)			
0	ig Phy ter this neral o		27. Manner of Death 28a. Date of injury 28b. Time o		28d. Describe how injury occurred			
5	eath. or: Af the fu	ifica	1 ✓ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	M 1 Yes 2 No				
noision	al or Att s after d il Direct ed in by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, str	eet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check conly one) 1 Certifying Physician: To the best of my knowledge, death (Check conly one) 1 Medical Examiner: On the basis of examination and/or investorily one) 3 Certifying Nurse Practitioner: To the best of my knowledge	tigation, in my opinion, death occurred a	t the time, date and place, and due to the cause(s) and manner stated.			
	To the vithir To the comp	- 1	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)			
			MY WULLS MP	1721119	14-11-12			
			30 Name and address of person who completed cause of death (Item 23a) (Type, I	E. 6BMC 656	5 N. Charles Towson 21204			
	Stat Registra		31. Date filed (Month, Day, Year) APR 2 3 2012	K				

12-02725 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Vera Carpenter State of Maryland / Department of Health and Mental Hygiene 2012 12485 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Year **Medical Examiner** Vera Carpenter 1107 hrs April 6, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Salisbury Wicomico 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) **Funeral** Months Days Hours Director 082-30-3059 2X F Country 1 M 73 26 1938 New York Usual Residence of Decedent 10b. County in 10a, State 10c. City, Town or Location 10d, Inside City Limits is 23a or 28a-f show e notified at once. 1 Yes 2 No or 28a-f show MD Somerset Eden Pages 1 and 2 should be filed within 72 hours after death with the Maryland net of Health and Mental Hygiene. Director 10e, Street end Number 10f. Zip Code 10g. Citizen of What Country? 14538 Jackson Blvd 21822 USA Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. 14. Race - American Indian, Black, must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Yeer traumatic event, the Medical Examiner Yes 2 No specify: Specify. 2 white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed unk during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) secretary 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Maxwell Hart Haines

19a. Informant's Name/Relationship (Type, Print) rlene Mikles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>James Carpenter/spouse</u> Jackson Blyd Eden. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) or other 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other Specify ROLLATU Sicensee 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 2 21201 <u>Baltimore</u> MD rt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** fail List only one cause on each line Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentielly list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last After this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial - transi Physician/Medical UNPENDED AMENDED To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? é 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b, Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 ✔ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) å examiner? Hospital: 1 Inpatient 2 PER/Outpatient 3 DOA Other | Nursing Home 5 Residence 6 Other ၉ 1 Yes 28a. Date of Injury (Month Day,Year) Apr 6, 2012 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Subject driver struck by minivan on driver's side Division 1 Natural 1038 hrs 1 Yes 2 ✔ No 5 Pending filled in by the lat intersection 2 🗹 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Route 13 at Eden Allen Road, Eden, MD determined (Specify) Major Road / Highway 4 ___ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 7, 2012 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) Registrar's Signat State APR 23

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month 20/Z 7 05 PM Physician/ Chack . Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Hours Min 1 🔀 M 2 🗆 F **Director** North Land 28a-f show 10b. County 10c. City, Town or Location Director Baltimore 1 Yes 2 No must be notified 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or U.S.A 23a Funeral 21215 2501 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 1 Yes 2 No
If Yes, Give Examiner Black White, etc. 0 þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced lack Completed Year or Dates 16a. Decedent's Usual Occupation

16a of work done during most of working intal Hygiene. 16b Kind of Business/Industry 15. Decedent's Education (Give kind of work done life, DO NOT use retired (Specify only highest grade completed, College (1-4 or 5+) Elementary/Secondary (0-12) Be 18. Mother's Name (First, Middle, Maide, 17. Father's Name (First, Middle, Last) marked o Brooks မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 27 20b. Place of Disposition (Name of cemetery, crematory or other) 20a Method of Disposition ₩ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or -27-2012 Donation 5 Other (Specify) Signature of Funeral Service License any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Inset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h Yes 26. Place of Death (Check only one) filled in by the funeral director, 25. Was case referred to medical To Be examiner? Hospital: Other: 2 No 1 Yes 1 Inpatient 2 I ER/Outpatient 3 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signatur PARK, WWD 700 km/M Washina 31. Date filed Month, Day, Year) State

OHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 VIRGINIA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany Cumberland WEstern MD Health System If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months Director 214-46-3104 1 M 2 XF May 31, 1944 Maryland 67 Usual Residence of Deced 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland must be notified at Director 1 🗆 Yes 2 🔀 No MD Mt. Savage Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a P.O. Box 404 21545 USA items death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, event, the Medical Examiner Armed Forces? Black, White, etc. 1 and 2 should be filed within 72 hours after the Health and Mental Hygiene.
Item 27 is marked other than "natural" or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 cleaning person community center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leroy Harris other traumatic Elsie Mears 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 W. Main Street #6 Frostburg, MD Karen Carder/daughter 21532 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. Date Page 1 cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🕅 Donation 5 🗆 Other (Specify) permit. 22. Name and Address of Facility
State Anatomy Board
Baltimore, MD 21201 Konald irector 655 W. Baltimore Street m 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PSIS Medical resulting in death) Examiner Sequentially list conditions, If any mading to immedi cause. Enter Underlying Cause (Disease or injury Exami use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicial completely filled in by the funeral director name 2 should be detected. Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death . Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) R089384

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Denise K. Bither CRNP

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Stanley April 10:30 PM Leroy Dayhoff Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Golden Living Center Westminster Carroll Social Security Number If Under 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** If Under 24 Hrs 8. Date of Birth Month, Day, 1 🔀 M 2 🗆 F Months Days Hours Min Director 218-24-9922 Yrs 82 Jun. Maryland Usual Residence of Decedent show 10a. State 10b. County with the Maryland items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d, Inside City Limits Director Maryland 1 Yes 2 X No Carroll Union Bridge 10e, Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 58 Pipe Creek Road 21791 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced 1951-53 White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 8 assembly line worker shoe factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Dayhoff Deborah Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Heath an Important: If item 27 is any injury or other trau Dorothy Dayhoff/ wife 58 Pipe Creek Rd. Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Un. 4/17/2012 Meth. Cem. Shipley, MD 21. Sign of Funeral Service License 22. Name and Address of Facility Hartzler Funeral Home, P.A. atharine 310 Church New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or burial-transit and that initiated events resulting in death) Last Due (or as a consequence of) attending physician for use as the hurial Physician/Medical 25 Division of Vital Records. P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months Day Month Year Pregnant at time of death the 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an e Hospital or Attending Physician: The law r 124 hours after death. e Funeral Director: After this certificate has b leted filled in by the funeral director, page 2 st autopsy performed? 2 1 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗆 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗆 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of d 29c. License number

DHMH 17 Rev 7/2009

State

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ra 31. Date filed (Month, Day, Year)

3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 12489 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 2012 3:00 A. Judith E. Ebberts Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Randallstown Cassandra Ct. 8. Date of Birth
(Month, Day, Year)
Sept. 7,1941 Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Hours Director 217-40-9802 Usual Residence of Decedent 1 🗆 M 2 💢 F MD 70 or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director oms 23a or 28a-f sh r must be notified a 1 Yes 2 No Maryland Baltimore Randallstown 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21133 United States 2 Cassandra Ct. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten ledical Examiner r 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc by 1 Never Married 2XX Married 1 ☐ Yes 2 XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. Specify White 3 Widowed 4 Divorced Completed Year or Dates 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Loyola College 12th Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nelson Mayne Ida Crowl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 27 is i April Rose Daughter 1100 Algernon Drive Westminster, MD Important: If item 27 any injury or other to once, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Lake View Mem. Park April 12, 2012 Sykesville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Burrier-Oueen Funeral Home & Crematory, PA 1212 W. Old Liberty Road Sykesville, MD 21784 emu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or heart failure. List only one cause Immediate Cause (Final Physician/ Melanona Metastate disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery been signed by the atter in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate Yes funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Dear 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely within 2. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe D3875 8/12

Registrar
DHMH 17 Rev 06-2011

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State

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whelle MD

21097

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12753

32. Registrar's Signature

SharFna

. Date filed (Month, Day, Year,

APR 2 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician VIVIAN APRIL 18 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 KF Days 242-08-2806 54 **Director** FEB 12, 1958 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show BAHIMORE 1 Nes 2 No Director er than "natural", or items 23a or 28a-f s the Medical Examiner must be notified 10e. Street and Number 10g. Citizen of What Country? DIOMAC Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Culban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 💈 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: BIK 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the M. Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BINNO VIVIAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) UNDER DUE 135 WILLOW BEND Dr. 2D OWINDS MILLS MD 21/17 KEVIN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 27 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)* CATONSVILLE, MD CreMATORY 22. Name and Address of Facility
Micheel Ziglier FUNETAL SVC PA.
3512 Frederick AVE. BAHO. MD. 21229 21. Signature of Feneral Service Licensee 21. Signature of Feneral Service Decrises

Muchael 3490000

23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner RESPIRATURY HYPERCARBIC The law requires that the death certificate be executed attending physician and dor use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown P.O. the 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate has 2 🗌 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Impatient 2 - ER/Outpatient 3 - DOA 2 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Tes ၉ within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident the Hospital or Attending 5 Pending investigation Injury 1 🗌 Yes filled in by the 6 Could not be determined 3
Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29b. Signature and title of certifier MD RES-000 18 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2012 11:00 P ^M Amy Marie Forrest 3 April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examine St. Thomas More Nursing & Rehab Ctr. Hyattsville Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛣 F 37 1974 Dec. 30, Virginia **Director** Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f shown the Medical Evanings must be notified at 1 ☐ Yes 2 XNo Director Maryland Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4922 LaSalle Road 20782 U. S. A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 d 2 should be filed with and Mental Hygien 7 is marked other the Bagger Safeway Grocery permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lemuel Forrest Ellen Brooke ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lemuel Forrest/Father 504 Stratford Circle, Locust Grove, Virginia 22508 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State Flint Hill Cemetery 4/07/2012 | Oakton, Virginia 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Money & King Funeral Home, Inc. Gary R. Downer Hary K bowner CCo 508 171 W. Maple Ave., Vienna, Virginia 22180 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Atherosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): las of Motor Vehicle Accident Examiner MulTople Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and burial-tran Due to (or as a consequence of): Physician/Medical the attending philor for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ▼No Month Year Day 5 ☐ Other (specify) signed by the a 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ Respiratory Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Quadriplegia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? Ves 2X No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☑ No n 24 hours after death.

le Funeral Director: A

bletely filled in by the fu investigation 3/28/2011 5:30 A Pedestrian Struck 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Soapstone Dr. at 4 Homicide Sunrise Valley Dr., Reston, Va. Leaving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

within 7 2

the

death with

72

certificate be executed

Box 68760.

P.0.

Records,

Division of Vital

Hospital or Attending Physician:

death.

Baltimore, Maryland 21215-0036

State Registrar

Ajit Kurup, MD 31. Date filed (Month, Day,

29b. Signature and title of certifier

(Check only

1835 University Blvd, #208, Hyattsville, Maryland 20783

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

1006368

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ida Ethel Flack /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ranklin Square more 410 8. Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign Country) West Virginia 6. Sex Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 X F 97 219 22 3636 Oct.18,1914 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location show 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Expression of the profiled on once. Baltimore Middle River 1 ☐ Yes 2 ☑ No Director Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1 Alloy Circle 21220 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No If Yes, Give Year or Dates: Specify. Specify: White 2 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Production Worker Aerospace 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Littlepage Alice Gayner ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra L. Cardarelli (Granddaughter) 1 Alloy Circle Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens 4/24/2012 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) rent Funeral Service 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A W. 1407 Old Eastern Avenue Essex, Maryland 21221 orm 23a. Fat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** + noin te disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed Due to (or as a consequence of) burialattending physician for use as the burial Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 No has , page 2 Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No of Vital After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Mpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. Sanchez-Crespo M-D9000

29b. Signature and title of certifier

29c. License number

DUU67697

Franklin Square

29d. Date signed (Month, Day, Year)

Dr. Balto, MD, 2123/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles Edward Francen Month 4:20 P M Apr 19, 2012 Year Medical 4c. County of Death

Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Timonium** Stella Maris (Cardinal Shehan Center) 8. Date of Birth (Month Day Year) Mar 1, 1918 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Hours 135-05-9816 94 Country) **Director** 1 **№** M 2 □ F 28a-f shov Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD **Baltimore** Catonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16 E Montrose Manor Ct. 21228 U.S.A. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No 8/22/1946 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. If Yes, Give 11/15/196 should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", Specify 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired, Elementary/Secondary (0-12) College (1-4 or 5+) Lt. Colonel **US Army** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ unknown 2012 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 E Montrose Manor Ct. Catonsville, MD 21228 19a. Informant's Name/Relationship (Type, Print) Rhoda L. Francen Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🕱 Burial 2 🗌 Cremation 3 🗐 Removal from State St. John's Cemetery Apr 23, 2012 Ellicott City, MD 4 Donation 5 Other (Specify) 22. Name Silack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Aneral Service 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. It is only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition LYMPHOMA Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of) physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be exec Physician/Medical Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No ρ Month Year Pregnant at time of death Day ed by the a detached f Unknown 9 Unknown Division of Vital Records, P.O. After this certificate has been signed by funeral director, page 2 should be detac Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHARLES FRANCEN ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ျ 1 Tyes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Cher (Specify) HOSPICE 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature and title 4+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **CRNP** 2300 DULANEY VALLEY RD. MORGAN. TIMONIUM, MD 21093 State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of Maryla	•	artment of rtificate of			giene Reg. No. 2	112	12491
Physic	ian	Registrar 1. Decedent's Name (First, Middle, La			Timeate of	Death	2. Date of Dea	ath Day	Year	3. Time of Death
/Medi Exami	cal	4a. Facility Name (If not institution, give	J. tart	a	4b. City, Town,	or Location of Death	Hpril		2012 nty of Death	23 PM
Funeral Director		5. Social Security Number 6.	Sex 7. Age (In y	rrs. last birthday) 15 Yrs.	Booth If Under 1 Year Months Days		8. Date of Birth (Month, Day	, Year)	9. Birthpl	
D	_	Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo				1-11-21		0d. Inside City Limits
the Ma 28a-f	Director	MD Baltimo	re	Balti	Baltimore 10f. Zip Code				of What Coun	1 ☐ Yes 2 ☐ No
ath with 23a or	ralDi	6718 Chisholm Dr			21207			1 =	USA	
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 No	Hispanic Origin? (S ban, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	Spec	lace - America Black, White, e cify: wh	
filed within 72 hou Hygiene. Ither than "natura ent, the Medical E	Completed	15. Decedent's Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	DO NOT use retir	e during most of wor ed)	rking		Business/Ind	·
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permit. Pages 1 an Department of Heal Important: if item 2 any injury or other once.		20a. Method of Disposition 1	20l	b. Place of Dispo		1	Date		n - City or To	
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hysician /Medical		23a. Pan Enter the disease or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	y one cause on each line.	proce	ter the mode of dy	ring, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
Examiner	<u>-</u>		b. Due to () r as a cond	equence of): Oloch sequence of):	Obstructive Pulmonomy Dise					
icate be executed physician and sthe burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or a a consequence of): Due to (or a a consequence of):								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ F	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)					23d. Date of delivery Month Day Year	
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The law requires t cate has been signe page 2 should be o	Completed						24a. Was autop perfo 1∐ Yes		prior to cor death?	psy findings available npletion of cause of 2 ☐ No
sician: T certificat irector, pa	o Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 □ EP/Outpatie	26. Place of Death (Check only o					
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tal or Atters after des al Directo	Certification:				28f. Location (S City or Tox	Street and Nu vn, State)	mber or Rura	l Route Number,		
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To the Compl	Me	29b. Signature and title of certifier	A . M	D	29c. License number D'31464			29d. Date signed (Month, Day, Year)		
		30. Name and address of person who	a completed cause of death (Itom 22a) /Tuno	Drint\		000-			2
St Regist	ate	StbAII3 A. ITASt. 31. Date filed (Month, Day, Year)	2. Registrar's Si	N. ZUTY	AN ST	Snite 31	ud Isati	rimor	e MID	21201

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 A M 1:50 Anita Gordon Gamson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Hebrew Home Of Greater Washington Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🗓 F Hours (Month, Day, Year) Director 470-16-4044 95 Minnesota Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MDMontgomery Chevy Chase 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20815 United States 4620 N. Park Avenue #604 W. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces? 1 ☐ Yes 2 ZNo Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Specify: White 3X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Therapist County Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Louis Gordon Sarah Jaffee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7318 Piney Branch Rd. Tacoma Park, Maryland 20912 Neil Gamson - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 💹 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gardens 4-22-2012 Olney, Maryland 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility Edward Sagel Funeral Direction Blake "Kurt M01477 1091 Rockville Pike, Rockville, Maryland 20852 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final NEUMONIA Dh_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** ORGANISMS DENTIFIED I Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying ending physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No ō Month Dav 5 Other (specify) Pregnant at time of death i signed by the ail 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 1 No 1 Tes 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has I autopsy performe this certificate Yes 25. Was case referred to medical examiner? **Division of Vital** director, 26. Place of Death (Check only one) Be Hospital: Other: 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury work? 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 🗌 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MONTROSE RI), LOCKUSILE, MD 20852 100 31. Date filed (Month, Day, istrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Medical Exami	ner	Torey Maurice Garrison	Month April 16, 20	Day Year 12	2243 hrs
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Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	1 ,	(MM/DD/YYYY) 9. Bir	gn
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at			
To ti To ti comp	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		9d. Date signed (Mor	
		O.C.M.E.		April 17, 2012	, Day, rear;
	-	30. Name and address of person who completed cause of death (Item 23a)			
21		Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD	21223		
		31. Date filed (Month, Day, Year) 32. Jegistrar's Signature			
Regis		ATK 23 CUIL Chaves A. Marke			
DHMH 17 Rev 1/2	UU1	ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3:198 Joseph H. Huggins, Sr. 20 2012 April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carrol1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours 219-32-3767 Director 1 X M 2 □ F 74vrs. 08/04/1937 Md. 28a-f shov at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Md. Carroll Finksburg 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21048 USA 4255 Poole Rd "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) ye 1 and 2 should be filed within 72 t of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Dry Wall Finisher Drv Wall other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William R. Huggins Jr. Mary Terry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy S. Huggins(Wife) 4255 Poole Rd. Gamber, Md. 21048. 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 04/24/2011 Sykesville, Md. 4 Donation 5 Other (Specify) Lakeview 22. Name and Address of Facility 21. Signature of Funger 18 Haight Funeral Home & Chap1 Box Svkesville.Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line ediate Cause (Final Interval Between Onset and Death Immediate Cause (Final Physician) disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): and Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown 2 No the a 9 Unknown s been signed by the should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perforn certificate | 1 ☐ Yes 2 ☐ No Yes I or Attending Physician: after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 X No 1 Yes ည 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA within 24 hours after deam.

To the Funeral Director, After this completely filled in by the funeral di 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

april 23 1 2012 NVD 21226 6 31. Date filed (Month, Day, Year State APR 2 3 2012 Registrar

29d. Date signed (Month. Dav. Year)

29b. Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Howard Robert Hampton 955PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Hospital Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Country)
MD 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 215-30-3838 1**X** M 2 □ F Director Aug 5 1935 Usual Residence of Dec 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MD Harford Darlington 1 🗆 Yes 2 🛣 No 10f. Zip Code 10g. Citizen of What Country? **USA** 4041 Conowingo Road Lot # 23 21034 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married 1X Yes 2 No Korea Maryland 21215-0036 1 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) law enforcement $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 11 \end{array}$ College (1-4 or 5+) police officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or next. Anna Marie Scheeler James Albert Hampton ToDO/9514 O 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 4041 Conowingo Rd. Lot 23, Darlington, MD 21034 Mrs. Anna L. Hampton (spouse) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial 4-25-12 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Dage Haight Herbert Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Chronic Respiratory Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying To Be Completed by Physician/Medical Examiner Due to (or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 1 ☐ Yes 2 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hampton performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) April 21,2012 HO054439 Name and address of person who completed cause of death (Item 23a) (Type, Print)) in cent A gimin Aro, Do 2012 South To Ugate Re 20 4 111, Bul An 31. Date filed (Month, Day, Year) APR 2 3 2012 State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:12p George William Harvey Sr. 18 April Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Westminster 4c. County of Death **Examiner** Carroll Hospital Center Carrol1 Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 27 1948 g. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Months Days 212-52-2877 Director 1 X M 2 D F 63 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director Sykesville MD Carrol1 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21784 6600 Overlook Court "natural", or items 12. Was Decedent Ever in U.S.
Armed Forces? 1967—
1 X Yes 2 No
If Yes, Give 1973 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status traumatic event, the Medical Examiner 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1973 1 ☐ Yes 2 🔀 No Specify: Specify: white 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) aerospace manager aerospace Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Clay Harvey Sr. Margaret Virginia Glover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6600 Overlook Ct., Sykesville, MD 21784 27 Mrs. Carole Harvey (spouse) Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem. Park 4-23-12 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Para Haight Lerbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical 33 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 No Division of Vital To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director, After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Thomas W. Golman D3(660 on who completed cause of death (Item 23a) (Type, Print) SEARL ALEXE LUES THE STER MANULAN GALVUN I MA 395 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

68760

Box

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 23a pt. I-b, pt. II, per phy, g927 5-10-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ A proph 342 Charles Hinerman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death ltospital Agnes Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 279-28-7774 **Director** 1 X M 2 □ F 79 08/04/1932 West Va. Usual Residence of Decede 28a-f shov 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director 1 Yes 2 No Md. Carroll Eldersburg 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5823 Westchester Hills Court 21784 USA items be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates 1947 –1752 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Social Security Yrs. Computer Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles H. Hinerman Mary Bolen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Hinerman (Wife) 5823 Westchester Hills Court Eldersburg, Md. 21784. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn 04/28/2012 Marriottesville, Md. 22. Name and Address of Facility Haight Funeral Home & Chapel PA P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician pheumonia Aspiration disease or condition d un Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transi attending physician and I for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? COPD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Z Unknown inerman, Charles Completed 24b. Were autopsy findings available prior to completion of cause of death? Pancreatic Cancer 24a. Was an has page 2 autopsy performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury 1 X Natural Accident Investigation completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NP1:1356659031 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Buddensick 900 Caton Ave Beltimore, Mo 5 State Registrar